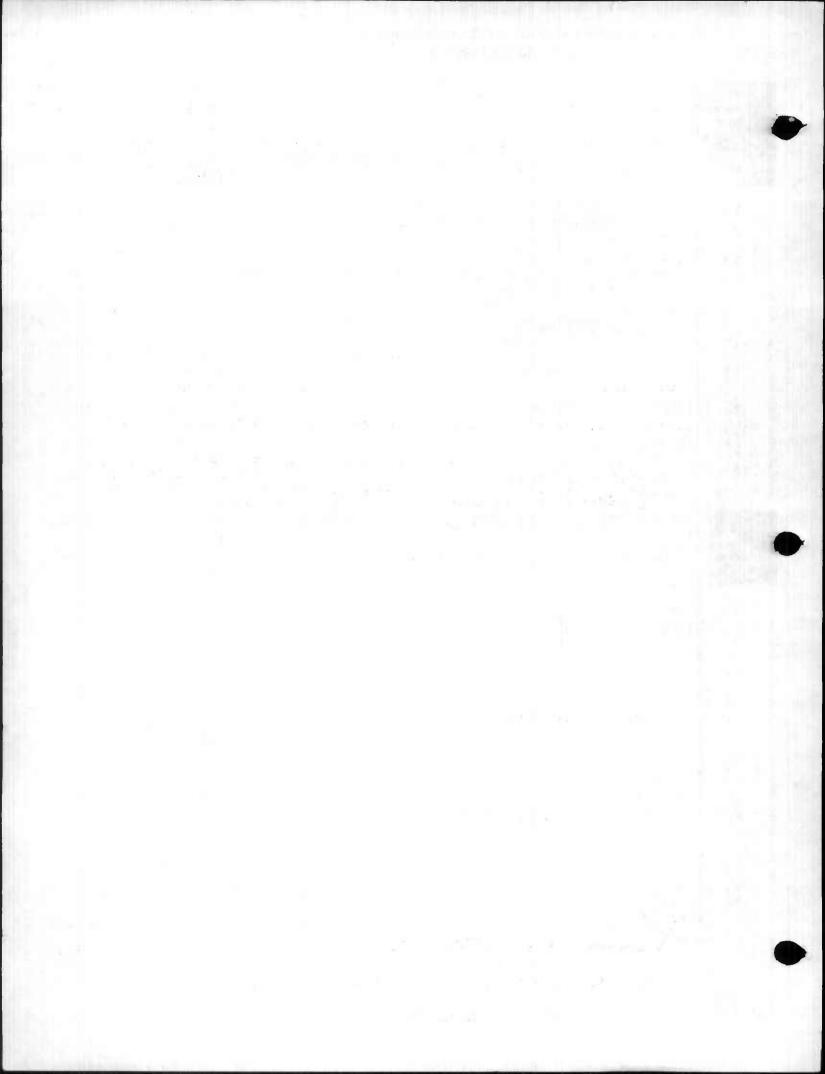
State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First	Middle I se	r)		Cel	tificate of	Deam	2. Dete of De	Reg. No.		3. Time of Deeth
Physici	an	James G.		,					Month	Dey	Yeer	
/Medic		4a. Facility Neme (If not in		etraat and num	harl			4b. City, Town, or	March			10:03 PM
Examir	er					. 1						
		Washingto	6. Se			al lest birthday)	If Under 1 Yee	Takoma P		Monte		
Funeral Director		578-14-8346 Usual Residence of Deced	1	M 2□F	82	Yrs.	Months Days		Aug. 3	rth ay, Year) I, 1915	Gree	eca (State or Foreign etry) ece
aryland show	-		County			ty, Town or Lo				1	0d. Inside City Limits	
Ba-f	cto		ntgome	ery		Silver	Spring					1 ☐ Yes 2 € No
or 2	Die	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Coun	ntry?
23a	<u>a</u>	818 Rowen Ro	ad					0910			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or frems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner main be notified at 900ce.	by Funeral Director	11. Marital Status 1 Nevar Married 2 3 Widowed 4 Di		12. Wes Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 🔯 No e		Ves Decedent of I Yes, specify Cu I ☐ Yes 2 2 No	Hispanic Origin? (S ben, Maxican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Specify	ce - Americ ck, White, y: Whi	etc.
n rzno	leted	15. De (Specify only	cedent's Edu highest grad	ucation fe completed)		16a. Deced	lent's Usuel Occi	upation e during most of wor ed)	rking	16b. Kind of B	usiness/Ind	dustry
giene. er than t, the M	Comp	Elementery/Secondery (0-12)	College (1-	-4or 5+)	-	oker	50)		Real	Estat	te
ental Hy	To Be Completed	17. Fether's Name (First, It Gus Cokas	fiddle, Last)					18. Mother's Ner	ne <i>(First, Middle</i> Panopou		ne)	
d Me	ř	19e. Informent's Neme/Re	letlonship (T	vne Print)		19h Mailir	a Address (Stree	et end Number or Ru	•		State Zin	Code)
th and					(wife)			ad, Silve			20910	. 0,000)
if of Heal if Item 2 or other		Constance Z. 20e. Method of Disposition 1 X Buriel 2 Cran	etion 3 🗆 I	Removel from S	20b. I	Plece of Dispo cemetery, crer	sition (Name of netory or other pi	lece)	Dete	20c. Location	- City or To	
tant:		4 □ Donetion 5 □ O			Ga	te of	Heaven (Cemetery C	3/19/98	Silver	Sprin	g, MD
Depar Impor any in		21. Signeture of Fuheral 5	ervice Licens	H	sec	Ho	ome, Inc	ress of Fecility F1 . 500 Un ring, MD				neral
hysician		23a. Pert1. Enter the dise shock, or heart feilur	ese, or comp e. List only o				er the mode of dy	ying, such es cardia	c or respiretory	errest,		Approximete Intervel Between Onsat and Death
/Medical xaminer		Immediate Cause (Final disasse or condition resulting in death)		е. Нер	atic Fa	ailure	uence of):					l week
dansit	edical Examiner	Convention to the operation	•	b	Due to /	or es e conseq	uence of):					
physician and s the burial-transit	al Ex	Sequentially list conditions if any, leading to immedie cause. Enter Underlying Causa (Disaase or Injury that initieted events		c							-	
C) 65	Medic	resulting in deeth) Lest			Due to (d	or as a consaq	uanca of):				1	
attendin for use	Physician/M			d							1	
by the a	ysic	Pert II. Other significant o	onditione co	ntributing to de	ath but not res	sulting In the u	nderlying cause (given In Pert I.	23b. Did	tobacco use co	entribute to	the cause of death?
igned by be detac	by Ph	Malignar	ıt lymj	ohoma				_	1	Yes 2⊠ No	3 Pro	babiy 4 🗆 Unknow
S S	Completed								24e. Wei perf	s en autopsy ormad?	av	ere autopsy findings aileble prior to mpletion of cause deeth?
ate h	200								1 🗆	Yes 2 No	10	☐Yes 2☐ No
this certificate	Be	25. Was case referred to r	nedical					26. Plece of De	eth (Check only	one)		
is ce direc	To	exeminer? 1 ☐ Yes 2X No		Hospital: 1 🖾 Ir	npatient 2	ER/Outpetier	t 3 DOA	ther: 4 ☐ Nursing H	Home 5 ☐ Res	idence 6 Oth	ner (Specif	(y)
The fact	Certification:	2 Accident	Pending investigetion	28e. Date o (Monti	of Injury h, Dey Year)	28b. Time of Injury	W	ury et ork? □ Yes 2 □ No	28d. Dascribe	how injury occur	rred	
aftar de Directo d in by t	Sertific	3 ☐ Suicide 6 ☐ 4 ☐ Homlcide	Could not be determined	28e. Pleca buildin	of Injury - At h ng, etc. (Speci	nome, farm, str fy)	eet, factory, office	9		(Street and Numi own, State)	ber or Rure	al Route Number,
vithin 24 hours after death. To the Funeral Director: A complately filled in by the f	edical C	(Check only 2 M	ertifying Phy edical Exami	sician: To the l ner: On the ba end menn	sis of exemine	owledge, deeth etion end/or Inv	estigetion, in my	time, dete end plece opinion, deeth occu	e, and due to the urred et the time	ceuse(s) and m , dete end pieca,	enner es s and due to	teted. o the cause(s)
vithin 7 to the comple	2	290 Signature end title of	certifier C). w	20th	w.	100000000000000000000000000000000000000	nse number		29d. Data signe		Day, Yeer)
		30. Neme end eddress of p	erson who c	ompleted cause	e of deeth (Ites	m 23e) (Type.						
		Martin D. We						Greenbel	t, MD	20770		
Sta	te	31. Dete filed (Month, Dey		T	egistrer's Sign							

Registrar

MAR 19 1998

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 2. Date of Death 3. Time of Death Month Dev

Physician /Medical Examiner

BEATRICE CONTRERAS

1. Decedent's Name (First, Middle, Last)

MARCH 13, 1998 10:30 PM

10d. Inside City Limita

white

20876

20877

Approximete Interval Between Onset and Death

1 ☐ Yes 3√ No

MONTGOMERY

Funeral Director

the Maryland show Directo Funeral þ Completed

r than "naturel", or items 23a or 28a-f short the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death with near of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or items 23a or intro yor other traumatic event, me to an an internal bar

Be

Baltimore, Maryland 21215-0020

Bly

Physician /Medical Examiner

permit. Page Department of Important: If any injury or

Examiner The law requires that the death certificate be executed physician and s the burial-transit Physician/Medical 80 attending US6 been signed by the s should be detached þ Completed certificate has t lirector, page 2 s Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifica director, 2 funeral Certification: After erel Director: / filled in by the f To the Hospital within 24 hours a To the Funeral Completely filled

Be

cal

ğ

Division of Vital Records, P.O. Box 68760,

4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 19308 CIRCLE GATE DRIVE, #204 GERMANTOWN II Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 10, 1905 Birthplece (State or Foreign Country) If Un r 1 Y 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1□ M 2√ F Yrs Texas 92 May 577-36-5256 Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County Maryland Montgomery Germantown 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? United States Drive, #204 20874 19308 Circle Gate Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status ☐ Yes 2♥ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Detes: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Bouffier Polidore Sosa 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19318 Elderberry Terrace, Germantown, MD Mary Louise Emmell, Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 Burial 2 M Cremation 3 Removation State Mar 15, 5 Other (Specify) 4 Do Metropolitan Crematory 1998 Alexandria, Virginia 21. Signa 22. Name and Address of Facility Funeral Service Licens DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD ake n or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final ATEL disease or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lesf Due to (or es a consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. Was an autopsy

23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 TYes 2 TNo 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 55 Residence 8 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Seleturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred of the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

POCKYILE.

29d. Date signed (Month, Day, Year)

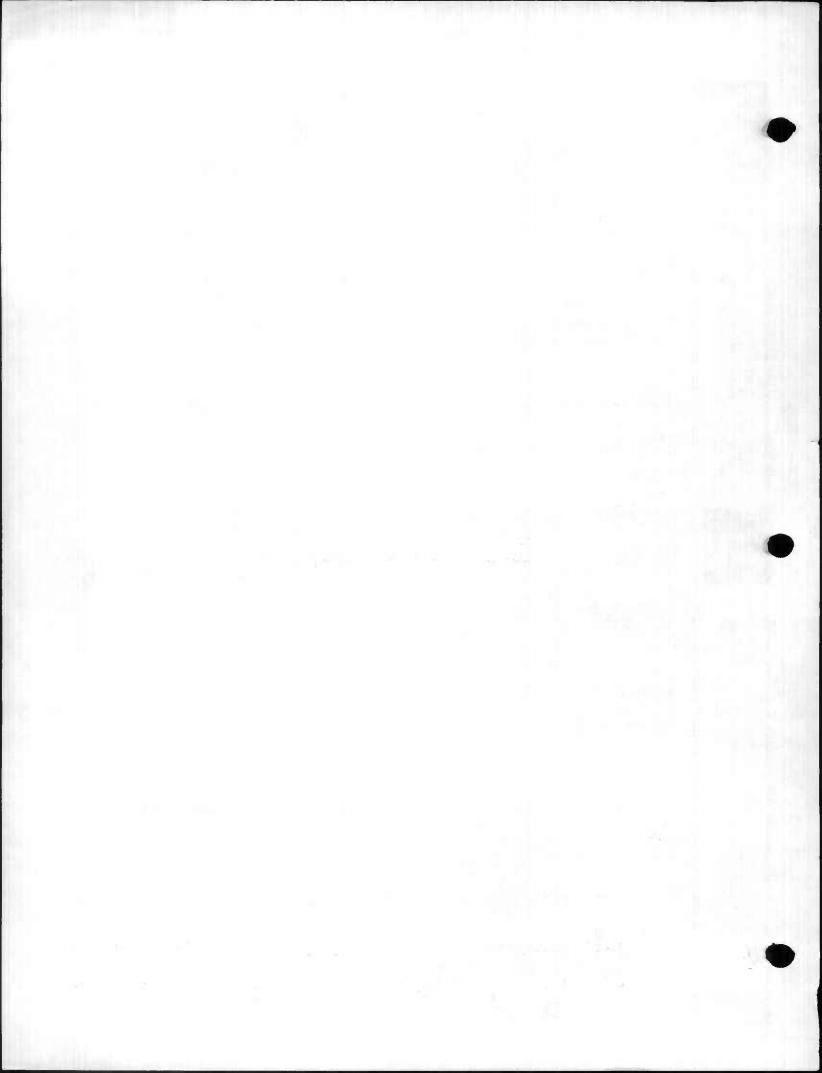
D42110

MARYLAND ZOBSO

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 15225

SHADY GROVE ROAD Register's Signatur Rando

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death March 14,1998 **Physician** 8:30 A.M. Peggy Jeanne Cooper /Medical 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Mariner at Circle Manor Kensington Montgomery If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. June 25, 1931 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stete or Foreign 6. Sax 1□ M 2♥ F Washington, DC 216-76-7221 66 Vrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10e. Stete 10d. Inside City Limits 1 ☐ Yas XX No Directo Maryland | Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1405 Milestone Drive 20904 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 0 No If Yes, Give Yaer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. Wever Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa refired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None / Never worked None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frances G. Green George E. Cooper 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Martin/cousin 13702 Woodland Heights Dr. Hagerstown, MD 21742 20b. Plece of Disposition (Neme of cematary, crametory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete No. Virginia Crematory Mar 16,1998 Arlington, VA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home, Inc. 21 Signature of Funerel Sarvice Lightens 254 Carroll St. NW Washington, DC 20012 back Enter in disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiretory arrast, or hearth edium. List only one cause on each line. Interval Batween Onset end Deeth Immediete Ceuse (Finel disaesa or condition resulting in death) area tellepoler Due to (or as a consequence of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequença of): Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ueknown þ 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an eutopsy performed? Completed 1 Tes 2 4No 1 Yes 2 No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 710 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide edical 1 🚾 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner es stated. 29a. Certifier 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. (Check only 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Neme end address of parson who completed cause of death (Item 23e) (Type, Print) FARRAGUT AVE. LENSINGTON, MD 20895 ROSENBADM 3720 31. Date filed (Month, Dey, Year)

State Registrar

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

with the Maryland

deeth

permit. Pages 1 and 2 should be filed within 72 hours after dee Department of Health and Mental Hygiene. Important if frem 27 is marked other theorems any injury or other traumous.

Physician

/Medical

Examiner

physicien end s the burial-transit

use es

signed by the a

funeral director,

this

Box 68760.

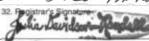
Division of Vital Records. P.O.

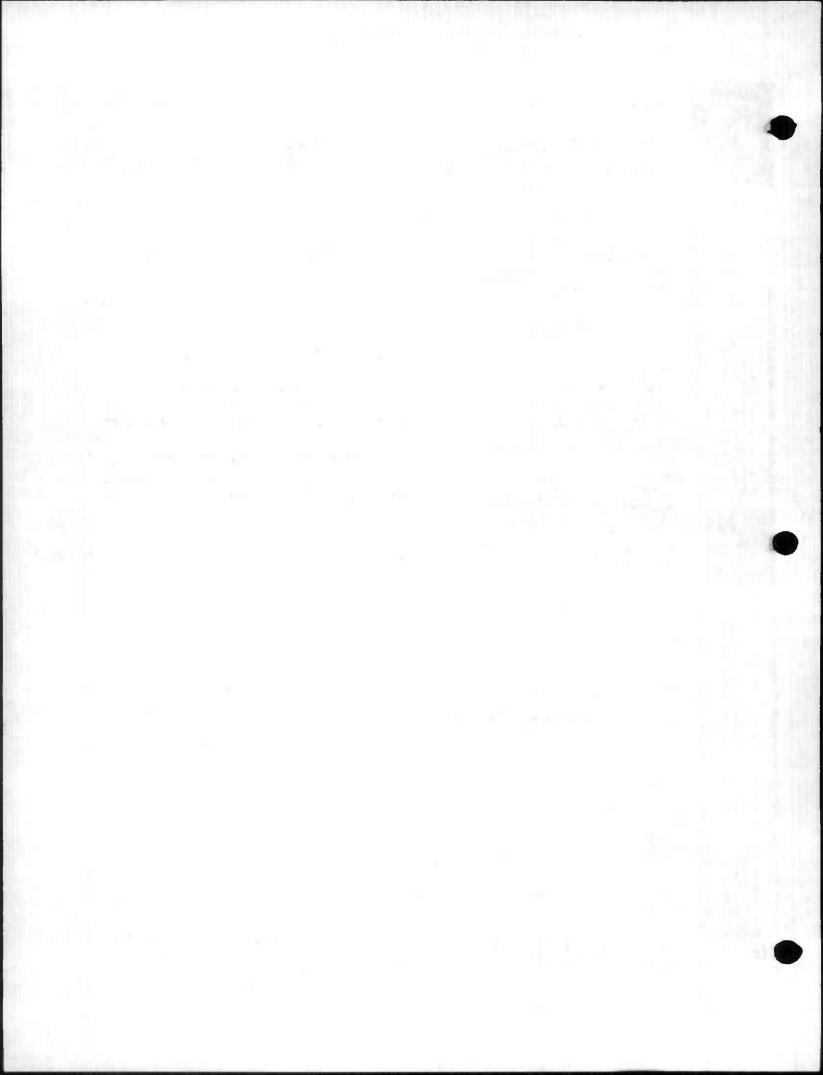
Attending Physician:

or Attending efter death. Director: Aft

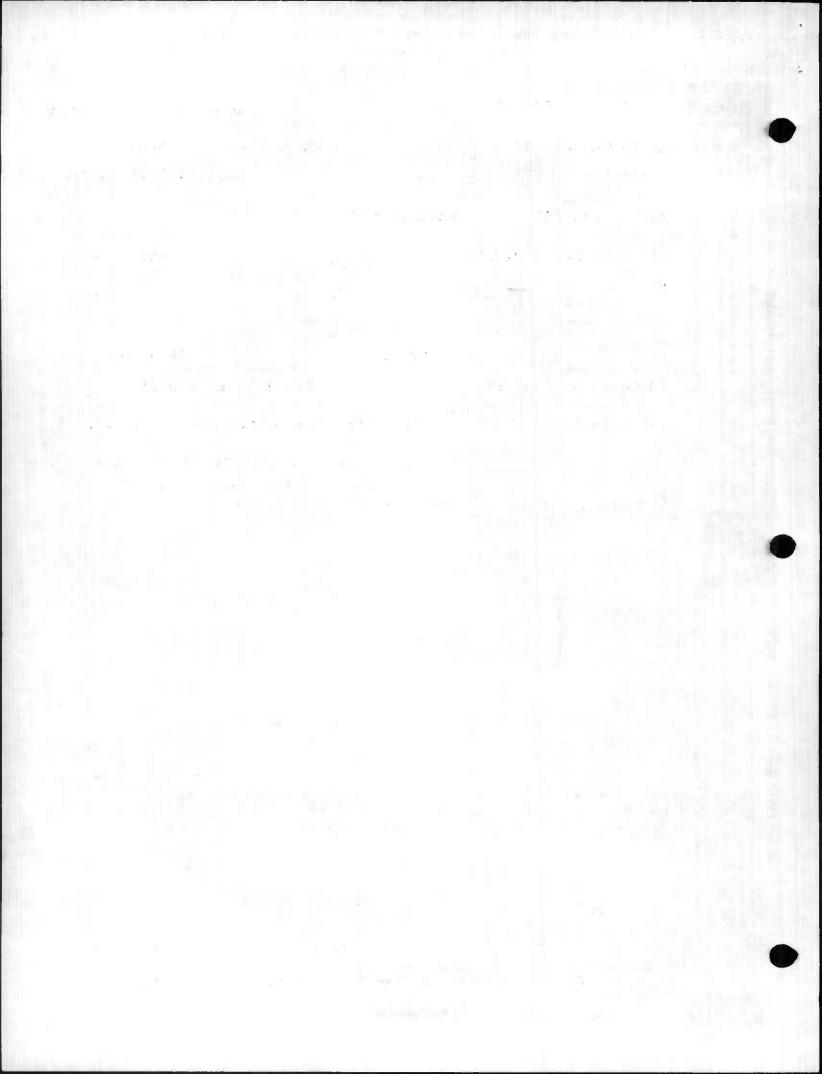
To the Hospital or within 24 hours aft To the Funeral Dicompletely filled in

18





Amended Item #12, per F.H., 3/17/98, Carroll County, wj1



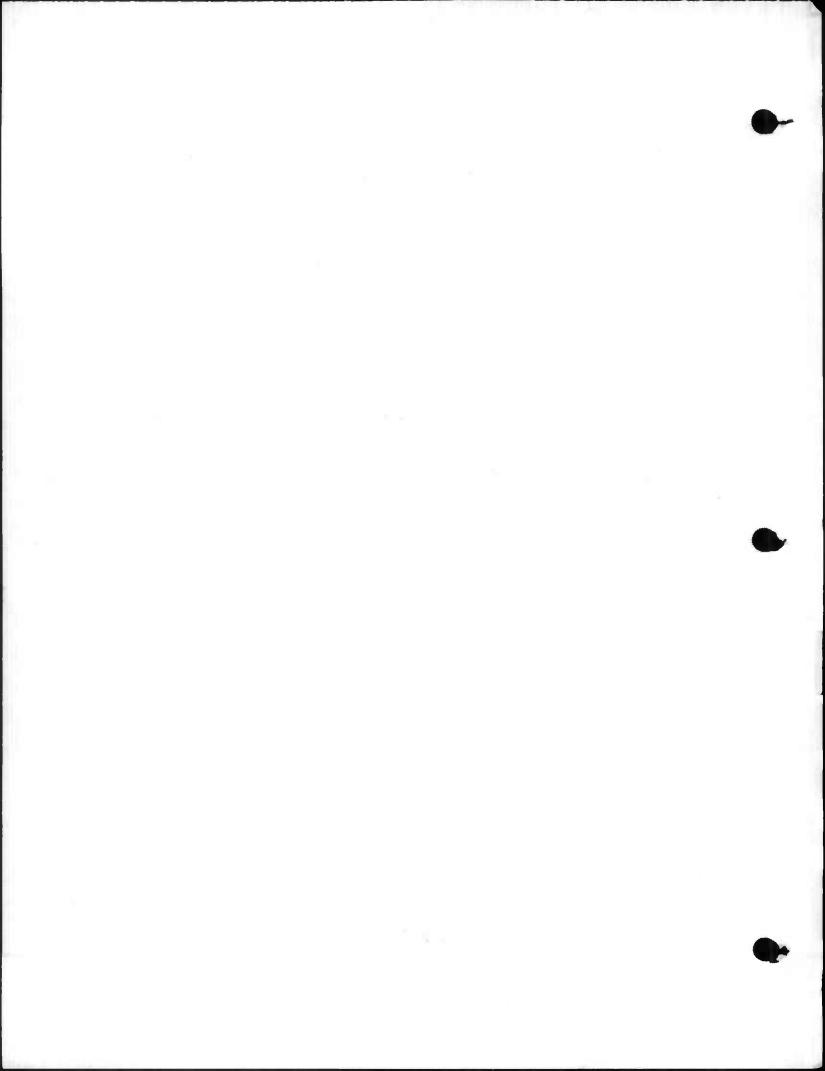
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, and hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

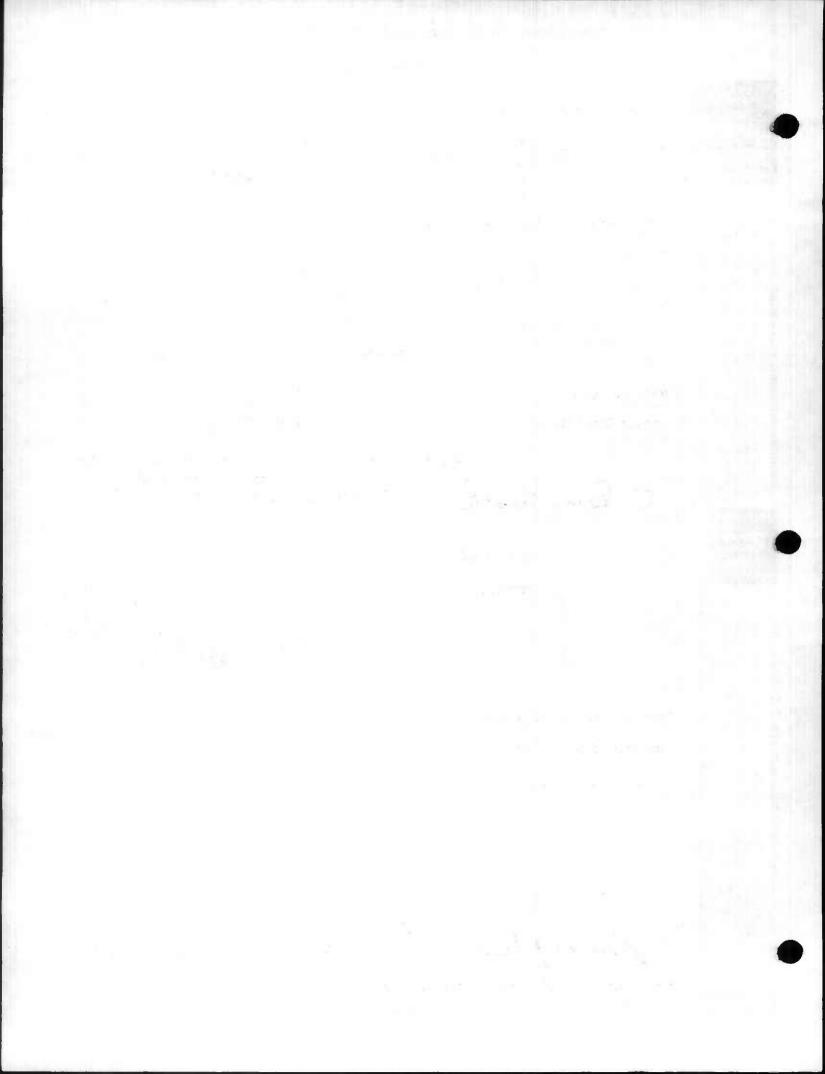
	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF H	EALTH AND N	MENTAL HYGIEN REG. NO.	E	10000							
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF OEATH							
	Clyde Wel	llington	Colbeth			March 7,	1998 YEA	8:25 P.M. M							
à	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGI	E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. Bit	RTHPLACE (State or Foreign							
	006-12-8050	1X M 2 □ F 8	O YRS.	MONTHS DAYS	HOURS MIN.	March 28,	1917 Ma:	ine							
	9a. FACILITY NAME (If not Institution, give s	treet and number)		96. CITY, TOWN	R LOCATION OF DE		9c. COUNTY O								
OB	Holy Cross Hospit	al		Silv	er Spring		Montgo	mery County							
ក្ត	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	v	100 0173	. TOWN OR LOCA	TON!			To a second							
DIRECTOR	Connecticut Harti			t Hartf				10d. INSIDE CITY LIMITS?							
	10e. STREET AND NUMBER				. ZIP CODE		100 CITIZEN O	1 X YES 2 NO							
H.	761 Burhnam Stree	o t		1	06108		United	States							
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED			C ORIGIN? (Specify Yes		Merica ACE — American Indian.							
	1 Never Married 2XX Married	FORCES? 1 X YES	S 2 NO OATES	If yes, sp	2 X NO Specify:	, Puarto Rican, etc.)	9	leck, White, atc.							
9 8	3 Widowed 4 Divorced	9/43- 8/45	WWII		QA.			white							
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of w	rork done during me	ON st of working	16b. KIND OF BUS	SINESS/INDUSTR	Y							
الا	Elementary/Secondary (0-12)	College (1-4 or 5+)	Employee	First		Cross	Dote	n 1 1							
Š	17. FATNER'S NAME (First, Middle, Last)		Nationa	1 Store				311							
	Clyde Wellington	Colbeth				Woodsum	or Town, State, Zlp Code) Oc. LOCATION — City or Town, Stata Cumberland, Maine e, One Mayberry Lane 6								
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street)			n State 7in Code								
임	Clyde Colbeth III	[/Son			e, Penns		, olale, 210 0000)								
	204, METHOD OF DISPOSITION	2	06. PLACE AND DATE O	F DISPOSITION (No	me of	March 20c. Los	CATION — City or	Town, Stata							
- 1	1 XBurial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)		Chebeague	Tsland	Cemetery	16,98 Cu	mberlan	ıd, Maine							
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE #M00690	0	22. NAME A	D ADDRESS OF FAC	ral Home	One May	herry Iano							
	Noward	X) Couse			th, Main		One nay	belly dane							
	23. PART I. Enter the disesses, or o	complications that caus	ed the death. Do n				ratory srrest,	Approximate							
	shock, or heart failure. iMMEDIATE CAUSE (Final			000	,			Interval Between Onset and Death							
	disesse or condition resulting in desth)	· RUP	Mren	MODON	IWA/ B	unde A.	~e varys	m 4 HRS							
- 1		DUE TO (OR AS	A CONSEQUENCE OF):	2. A~	0 .0		1.0							
CERTIFICATION	Sequentisity list conditions,	b. DUE TO (OR AS	A CONSEQUENCE OF	A LAS	JUIC VI	aora, 570	1	1916.							
A	if sny, lesding to immediate cause. Enter UNDERLYING			,				į							
Ĕ	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):											
	resulting in death) LAST	d													
ا د	PART II. Other significant condition	s contributing to death	but not resulting in	n the underlyin	csuse given in F	Part I. 24a, WAS AN	AUTOPSY :	24b. WERE AUTOPSY FINDINGS							
S		_		,	, g	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE							
요						1 TYES 2	No No	OF DEATH?							
HYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH YE	SINO	UNCERTAIN	i ka		1 TES 2 NO							
Ž	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		ONCERNATION	(A2)									
S I	EXAMINER?	HOSPITAL:	ripetient 3 DOA	OTHER:	5 Residence 8	Other (Specify)									
E	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	26b, TIME	OF 28c. INJ		28d. DESCRIBE HOW IN	JURY OCCURED								
B	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆				i							
TED	3 Suicide 6 Could not be detarmined	28a. PLACE OF INJUF building, atc. (Sp	RY At home, farm, st ecify)	reet, factory, offic		281. LOCATION (Street a City or Town, State)	nd Number or Run	al Route Number,							
Щ	THE PARTY OF THE P														
COMPLE		CIAN: To the best of my kno													
8	2 MEDICAL EXAMINE	R: On the basis of examinati	ion and/or investigation	i, in my opinion, d	eath occured at the ti	ime, data and pieca, and	d dua to the caus	e(a) and manner as stated.							
6	ATURE AND TITLE OF CERTIFIER	ΩV	0		29c. LICENSE NUME			ED (Month, Day, Year)							
	30, HAME ON ADDRESS OF PERSON WHO	COMPLETED ST	my			064	► MA	1 . 1 . 0							
	1/	SALA OCA		Print) 11119	1.11.11	. DV R.	th 1 .	MD &852							
		22 DECUTE TO THE CO	AL ATLUME		roquiil	e In pe	ir waa	1000 - 00-							
	MAR 12 199	18 Julia Das	ridson-Rande	e .											





State of Maryland / Department of Health and Mental Hygiene o

_					iaiyiai		tificate of	Death		Reg. No.	3	0006
	Physic /Medi		Decedant's Name (First, Middle, L. Harriet Louise	Cherry					2 Data of Dea Month	Day	Yaar 998	3. Tima of Death
ÿ	Exami		4a. Facility Name (If not institution, gi	va street and number	r)		10	4b. City, Town, or	Location of Death	4c. County	of Death	
			Chesapeake Health Ca	re Center				Amold		Anne Ar	undel	
	Funerai Director		220-56-0039	Sex 7. A 1□ M 🏖 F		last birthday) Yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs Hours Min.			9. Birthple Count Chio	ece (State or Foreig ry)
	show d at	-	Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	ation	10d.				
	N of Table M	Director		Anne Arunda	el Ar	napolis						1 ☐ Yes 2 🔯 No
	ith to	F	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	ry?
	ath v	Ta .	800 Bestgate Road				21401			United St		
020	fled within 72 hours effer death with the Maryland Hygiena. ther than "natural", or items 23a or 28e-f show ent, the Medical Examinet must be inotified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yas ② If Yes, Give Year or Dates:	? 【No		/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (S an, Mexicen, Puer Specify:	Specify Yas or No- to Rican, etc.)		ce - America ck, White, e	in Indian, etc.
0200-61212	within 72 ho ena. than "natur na Medical	Completed	15. Decedent's E (Specify only highast gr Elementary/Secondery (0-12)	ducetion ade complated) College (1-4or	5+)	16a. Deced (Give k life. D	ent's Usual Occup ind of work done O NOT use retired	pation during most of wo d)	rking	16b. Kind of B	Business/Industry	
7	filed withi Hygiena. other than	Co	12			Honen	aker			Home		
2	should be filed nd Mental Hygi marked other imatic event, I	Be	17. Father's Name (First, Middla, Las	1)				18. Mother's Na	me (First, Middle,	Meiden Suman	ne)	
0	2 should be f and Mental I is marked of aumatic eve	To	Claude M. Taylor					Eula Smit	h			
mai yiaiid	2 60 00 2		19a. Informent's Name/Relationship	(Type, Print)		19b. Mailing	Address (Street	end Number or R	ural Route Numbe	r, City or Town,	State, Zip	Code)
	and and n 27 in 27 in er tr		Cherry Crawford (Nie	œ)		1632 G	ilford Rd.	Columbus,	Chio 432	21		
Dalilliole,	of T T		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		9		ition (Name of etory or other plea Crematory		Date 03/09/98	20c. Location		
Dale	permit. Pages Department of Important: If it any injury or c		21. Signatura of Funeral Service Lice	nsae 0	0	Nama and Addre	ess of Facility John Glowester	n M. Taylo	r Funera	l Home,		
			23a. Part1. Enter the disease, or con	I ruel					-		21701	Approximate
,00,00	rdificate be assecuted as no physician and as the bunat-transit	Medical Examiner	Sequantially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	a cardiac a	Due to (o	or as a consequ	ence of):		Pou	in the	Short Contraction of the contrac	Sugar 15/99
200	tha death cert y the attending ached for use in	Physician/N	Part II. Other significant conditions	d.	hut aat saa	uding in the up	dadula acusa si	una la Dant I	1 22h Dida	W I	3	
	es that tha de igned by the a be datached	by Phys	left hip fracture o		out not res	orang in the un		en in Fait.	1 1	_		the cause of death
, ,	aw requir is been s 2 should	Completed	parkinsons disease	depression					24a. Was a perfor	an autopsy med?	con	re autopsy findings llable prior to apletion of ceuse leath?
	0 - 0	E	Urinary tract infec	tion					1 🗆 Y	es 2 No	1 🗆	Yas 2X No
	certificate	0	25. Wes cese referred to medical	CICI				26. Place of De	eth (Check only o			
5	Phys ral di	n: To B	examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	Hospital: 1 Inpat	ury	ER/Outpatient 28b. Time of Injury	3□ DOA Oth	ier: 4 🂢 Nursing I	lome 5 Resid	ence 6 Oth)
	l or Attending after deeth. Director: After I in by the fune	Certification:	2 Accident investigation 3 Sulcide 6 Could not to determined	28e. Place of In		ome, farm, stre		Yes 2□No	28f. Location (S City or Tow		ber or Rurel	Route Number,
1	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 152 Certifying Pl	nyalcian: To the best	of my kno	wledge, deeth	occurred at the tir	me, date end place	e, and due to the o	ause(s) and m	enner es sta	ated.
	in 24 in 24 in Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner s	of examina	tion and/or inve	estigation, in my o	pinion, death occu	urred at the time, o	late and place,	and due to	the cause(a)
1	vithin 2 To the	ž	29b. Signature and title of certifier	o 1	8		29c. Licens	e number		29d. Date signe	d (Month, E	Dey, Year)
			1 mul	The .	/		D41955			3-4	-9	0
		1	30. Name and address of person who	Completed cause of	death (Iten	n 23a) (Type F				/ /		
			Rebecca Elon, MD 27.					71012				
	Sta	to	31. Date filed (Month, Dav. Year)	32 ABacist	rar's Sinna	nu. ALID	m' mararar	u ZIUIZ				
	ાટ Registr	ar	31. Date filed (Month, Day, Year) 199	38 Julia	Davids	ature Ande	82					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month **Physician** March 6, Joseph Stephen Curtin 1998 11:00 P.M. /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Knollwood Manor Nursing Home Millersville Anne Arundel 8. Deta of Birth (Month, Day, Year) 9. Birthpiaca (Country)
Aug. 15,1918 New York if Undar 1 Yaar | If Undar 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** TOM 2□F 066-09-0145 79 Director Usual Residence of Dacadant death with the Maryland 10b. County 10c. City, Town or Location ahow 10d. insida City Limits ir than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at 1X Yes 2 No Funeral Director Maryland Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2 First Place 21401 USA 12. Wes Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11 Marital Status 14 Rece - American Indian Black, Whita, atc. filed within 72 hours after 1 Navar Marriad 2 Married 1X Yas 2 □ No if Yes, Giva 1 21215-0020 1 Yas 2 No Specify: Yaer or Datas: 1943-45 by 3 ☐ Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) Planner, Estimator permit. Pages 1 and 2 should be filled w Department of Heatth and Mental Hygier important: If Nem 27 Is marked other th any injury or other traumatic event, this any of the present the page. 4 yrs. Federal Government Baltimore, Maryland 17. Fathar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be John Dennis Curtin Mary Grant 2 19e. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, Steta, Zip Coda) Stephen Curtin/ Son First Place Annapolis, Maryland 21401 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata Lakemont Mem'1. Gardens 3-11-98 Davidsonville, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037 29/3 SOLOMONS ISLAMU RU. EUR
23a. Pan1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata fntarval Batween Onset end Death **Physician** her moma / week /Medical Immediate Causa (Final disaasa or condition rasulting in death) **Examiner** Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed
the brouns after death.
 Funeral Director: After this certificate has been signed by the attending physician and
the principle of the proper of the properties of the properties of the principle o Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequance of): P.O. Box 68760. Physician/Medical Due to (or as a consequanca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? evelo Ves Cu 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Division of Vital Records. Completed by 24b. Ware eutopsy findings evellabla prior to complation of causa of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28e. Data of Injury (Month, Day Year) Certification: 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 X Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarminad 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 1 Cartifying Phyaiclan: To tha bast of my knowledga, daath occurred et tha tima, data and place, and due to the causa(s) and mannar as statad.

2 Medical Examiner: On tha basis of axeminetion and/or invastigation, in my opinion, daath occurred at the time, dete end place, end dua to tha cause(s) and mannar stated. Medical 29a. Cartifiar completely (Check only one) To the within 2 To the 29b. Signeture end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) process Attending bocter March 9, 1998 Name end eddress of person who completed causa of death (Item 23a) (Type, Print) PASADENA, MO

RITCHIZ HOY

a Davidson-Randale

39. Bagistrar's Signeture

-V. CYRIAC.M.D 8109

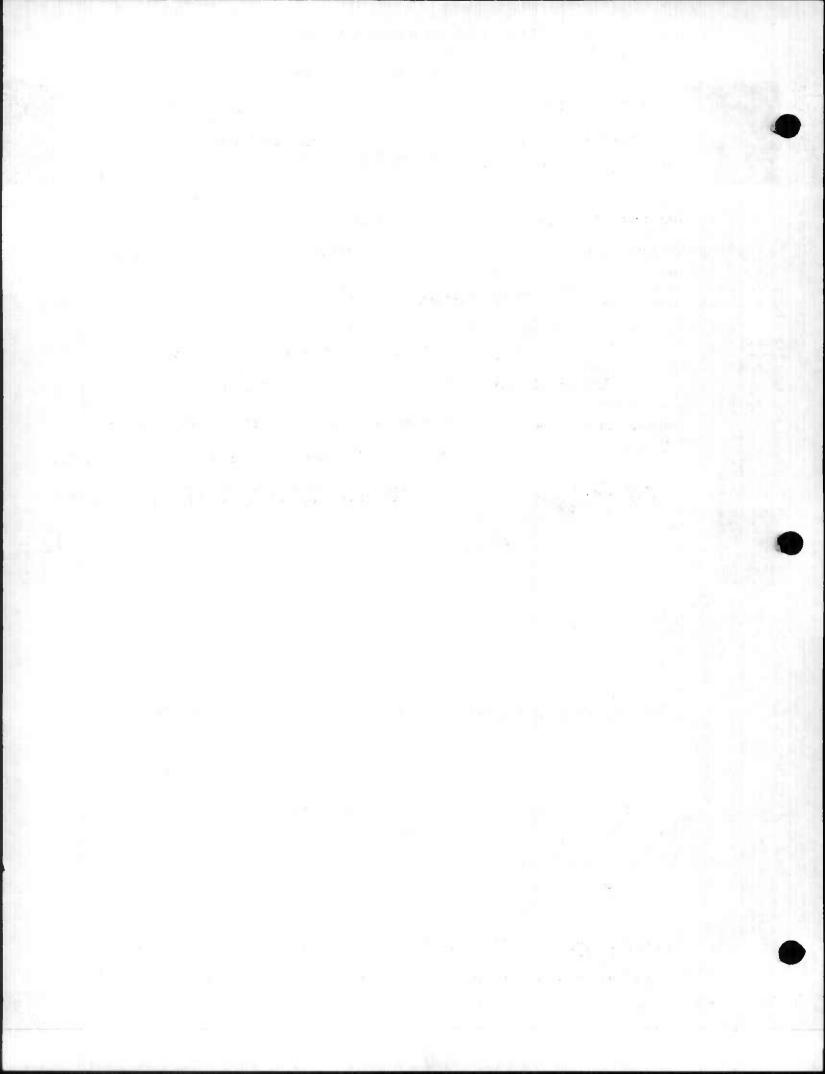
MAR 1 0 1998

31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar



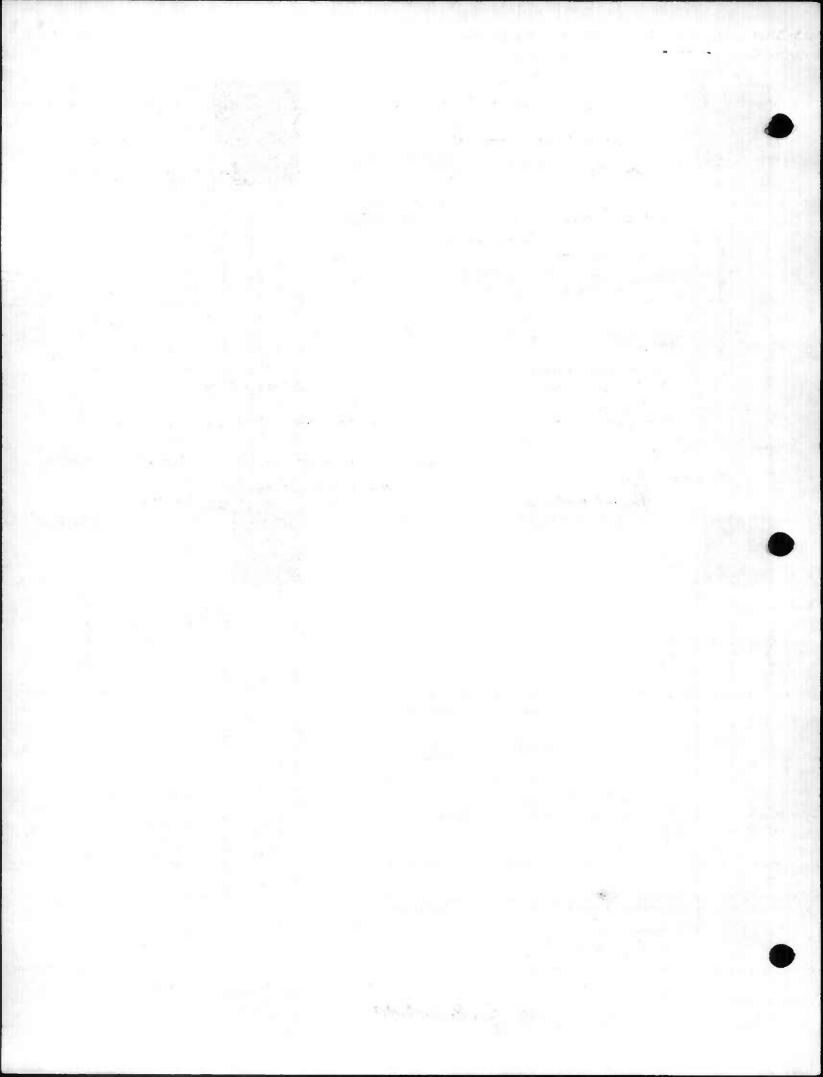
State of Maryland / Department of Health and Mental Hygiene 🔾 🔉

							Ce	rtificate of	Death		Reg. No.)	0008
	Physic		1. Decedant's Nam	na (First, Middia, Li	ast)					2. Data of D		Yaar	3. Time of Death
_	/Medi			MARY		ANN		COS		Marel		998	8:00 AM
3	Exami		4a. Facility Nama (If not Institution, gi	va street and nun	nber)			4b. City, Town, or	Location of Dea	th 4c. Count	ty of Death	
				Huntfi				- WAL 4 - 4 V		allsto		Harf	
	Funeral Director		5. Social Sacurity N 216-20- Usual Rasidance o	8206	Sex 1□ M 270 F	7. Aga (In yrs. 69	last birthday) Yrs.	If Under 1 Yaar Months Days		. (Month, D	irth Pay, <i>Year)</i> 1928		nplaca (Stata or Foreign untry) ryland
	death with the Maryland rms 23a or 28a-f show Liminat be notified at		10a. Stata	10b. County		10c. City	y, Town or Lo	ocation					10d. Insida City Limits
	Mar	Š	MD.	Har	ford			F	allsto	n			1 ☐ Yas 2 No
	or 28	Director	10e. Street and Nu	mber		,		10f. Zip Coda			10g. Citizan of	What Cou	intry?
	23a	lai	20	la Hunt	field	Court			21047		U.	S.A	•
	or des	Funeral	11. Maritai Status		12. Was Dece Armad For	dant Evar in U,	S. 13.	Was Decedant of lif Yas, specify Cub	Hispanic Origin? (ban, Maxican, Pua	Specify Yas or N rto Rican, atc.)	o- 14. Ra Bia	ce - Amari	rican Indian,
Maryland 21215-0020	filed within 72 hours after death with the Marylar Hygiene. Hyer than "natural", or items 23s or 28s-f show ent, the Medical Examener must be notified at	by	1 Mavar Marr 3 ☐ Widowed	ied 2 Married 4 Divorced	Armad For 1 ☐ Yas if Yas, Give Yaar or Da	a .		1□ Yas 2No					casian
5-0	"natural",	Be Completed	(Spec	15. Decedant's E	ducation ada complated)		16a. Dece	dant's Usual Occu kind of work dona	pation during most of wo	orking	16b. Kind of 8	3usinass/Ir	ndustry
121	d within piene. r than	Idm	Elemantary/Seco	ondary (0-12)	Collaga (1-	4or 5+)	life.						
2	o filed with al Hygiene. other than	ပိ	17. Fathar's Nama	(First Middle Lee	-	_		Clerk		ma (Eiret Middle	a, Maidan Suma		road
an	nd 2 should be filed the and Mental Hyg 27 te marked other traumatic evant, !	Be	Jo		thony	Cos				elina	a, marcari Surra		0.000
2	shoul mark	To	19a. informant's N			COS		no Addrass (Stree	t and Number or F		her City or Town		Scopaz
			Dolores		,	ter		same as			out, only or ton	, 0.1.1.0, 1.	, ,
re,	of Health I Nem 27 I		20a. Mathod of Dis	position		20b. P	lace of Dispo	sition (Nama of matory or other pla		3/240	20c. Location	- City or T	fown, Stata
E	~		1 Buriai 2 4 Donation	☐ Cramation 3 ☐ 5 ☐ Othar (Speci	∃Ramovai from S fy)	tata		n Cemet	*	1998	Baltir	nore	, Marylan
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signatura of Fu			24	-	2. Nama and Addr					y sacra y as cons
-			930 Dodd Folor	Sulled	den /	urg:		Jarr	ettsvi	lle, Ma	arylan	1	
	Di		23a. Part1. Entar t shock, or haa	na disaasa, or com rt taiiura. List only	ona causa on as	ich line	n. Do not ant	ar tha moda of dy	ing, such as cardia	ic or raspiratory	arrest,		Approximata intarval Between Onset and Death
	Physician /Medical		immediata Causa	(Final	90.	- 10 0 1		0011			-01		
	Examiner		disaasa or conditio rasulting in daath)	n	a. 294	a1910 C	15	CEII (arcin	oma	of wi	19-	months
		ner			0	DOJ OI BUC	r as a consec	quenca or):				V	
	eath certificate be executed attending physician and for use as the burial-trensit	Examiner	Sequentially list co	nditions,	b	Due to (or	r as a consec	quence ot):					
90,	requires that the death certificate be execut even signed by the attending physician and hould be deteched for use as the burial-tren	E	Sequentially list co if any, laading to in cause. Entar Unda Causa (Diseasa or that initiated events	nmadlata arlying								i	
68760,	cate b	Medical	that initiated events rasulting in death)	Last	Ç	Dua to (or	as a conseq	uance of):				1	
9 X	ding g			L	d								
Box	atten for us	lan											
P.O.	that the death co	Completed by Physician	Part ii. Other signif	icant conditions	contributing to dea	ath but not rasu	ulting in tha u	nderlying causa gi	van in Part i.				to the cause of death?
	that the ed by detect	y P	anemia	a, hyp	othur	oldis	sm. I	oneur	nonia	13	Yes 2□ No	3 ☐ Pro	obably 4 Unknown
Division of Vital Records,	w requires that been signed to should be det	Q P		,)!	9						s an autopsy	24b. V	Vara autopsy findings
000		ete	degen	erativ	re to	into	dise	ase		pert	ormed?	av Cr	vallable prior to completion of cause f death?
Re	The law ste has b	E C	5		٧					40	Vac OTDIa		
ta			25. Was casa retar	red to medical					29 Place of Do	ath (Check only	Yas 2 No		Yas 2 No
2	Physiclan: this certific rai director,	To Be	examinar?	Signal Continue	Hospital:	patiant 2	ER/Outpatier	nt 3 DOA Ot	har		idence 6 Ot	har /Snec	ifu)
0	ding Phys h. After this funeral di		27. Manner of Deat	h	28a. Data o		28b. Tima of			T	how injury occu		
io	eth. or: Aff	atio	1 Naturai 2 □ Accidant	5 Panding invastigatio	n	, Day Tour	прогу		Yas 2 □ No				
Ξ	r Att	Certification:	3 ☐ Suicida 4 ☐ Homicida	8 Could not be detarmined	Zoa. Place	of injury - At ho	ma, farm, str	eet, tactory, office		28f. Location City or To	(Street and Num	ber or Rur	ral Route Number,
Ω	illed i												
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifiar (Check only one)	1 Certifying Pt 2 Medical Exar	nysician: To the to niner: On the bas and mann	sis of axaminati	wledge, death ion and/or inv	occurred at tha ti vastigation, in my	ma, date and plac opinion, death occ	e, and due to the urred at tha tima	cause(s) and m , data and piace	annar as i	stated. to tha causa(s)
	To the Com	2	29b. Signatura and	titia of certifiar				29c. Lican	sa number		29d. Data sign	ed (Month	, Day, Year)
				1 5	7 >	/	-	1)	2438	3	3/1	8/9	8
	8		30. Nama and addre	ess of person who	completed causa	ot death (item	23a) (Type,	Print)	5500	took	m Pe	Ve	. Civek
			U. 63	Cre	Cha	eger	21	, O-	Ball	7	710	52	4
	Sta Registr		31. Data filed (Mont	th, Day, Year) 2 1998	32. Rg	gistian's Signa Lucium de	Jall						

DHMH 16 Rev 6/95

			-	State of	f Marylar			of Health and of Death		ienę.	10	009
	Physici		1. Decedent's Neme (First, Middle, La Edward	sn) Robbin	ns Ca	nnon			2. Data of Deat Month March	19,19	Year 98	3. Time of Death 1:30 PM
ì	/Medio Examir		4a. Facility Nama (If not institution, given Dorchester Gene					4b. City, Town, or Cambr	Location of Death	4c. County	of Death	er
	Funeral Director		5. Social Security Number 6. S 201-05-4755		7. Aga (In yrs. 76	last birthday, Yrs.	Months D		s. 8. Date of Birth	Year)		ce (Stete or Foreign
	e Maryland Sa-f ehow	ctor	Usual Rasidance of Decedant 10a. Stata 10b. County Maryland Dorche	ster	10c. Cit	ty, Town or L Camb	ocation oridge				100	d. Inside City Limits 1 ☐ Yes XX No
	23a or 2	Funeral Director	10a. Street and Number 110 Bayview Aven	ue			10f. Zip Co	da 1613	11	0g. Citizen of \US	Vhat Countr	y?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 ie marked other than "natural", or items 23a or 28a-f show any follupy or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Stetus 1 □ Nevar Married XXXX Merried 3 □ Widowed 4 □ Divorced	12. Was Deca Armed For 1/L/Yes If Yas, Giv Yaar or De	2 □ No a τ.π.τ		Was Decedant If Yas, specify 1 ☐ Yes 2 ☼	of Hispanlc Origin? (Cuban, Maxican, Pua No Specify:	Specify Yes or No- rto Rican, atc.)		e - Amarican ck, White, et : Whi	c.
Baltimore, Maryland 21215-0020	d within 72 ho giene. r than "natur	Completed	15. Decedent's E (Specify only highast gra Elamantary/Secondary (0-12)	ducation ada com <i>plated)</i> College (1	-4or 5+)	(Give	edent's Usual O a kind of work d DO NOT use re	ona during most of we	orking	16b. Kind of Bi		
ryland	nould be filed Montal Hygnerical	To Be C	17. Fathar's Nama (First, Middle, Last, Noble S. Cannon			40. 44. 7		Elsie	Robbins			
ore, Ma	of Health and item 27 le r		19e. Informant's Name/Relationship (Mary Ann Cannon 20a. Method of Disposition	Wii	20b. I	110		reet end Number or F v Avenue C of r piace)	ambridge,	-	and 21	613
Baltimo	permit. Pag Department Important: If any injury o		1 A Burial 2 Cremation 3 C 4 Donation 5 Other (Specification of Funeral Section 21, Signature of Funeral Section 21	(y)		2	Thomas I	ddrass of Facility Funeral Ho	me, P.A.			laryland
-	Physician		23a. Paul Enter the disease, or com- attack, or heart feilure. List only	plicetions that con a causa on a	aused tha daal ech lina.	th. Do not an	700 Loct ntar tha moda of	1st Street dying, such as cardio	Cambridg ac or raspiratory arm	e, Mary	1	21613 Approximata ntarval Batween Onset end Death
	/Medical Examiner	er	Immediata Cause (Finel disaase or condition resulting in daath)	a. Id	Plopath Due to (or as a conse	quance of):	Fibrosi:	\$		6	2 months
,00	ate be executed hysician and the burial-transit	i Examiner	Sequantially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disaase or Injury	b	Dua to (d	or as a conse	quance of):					
Box 68760,	ding p	n/Medical	that initiated evants resulting In death) Lest	d	Dua to (d	or as e conse	quence of):					
P.O. B	death e atte	Physician/Me	Part II. Other significant conditions of	ontributing to de	eath but not ras	sulting in the I	underlying caus	a given in Part I.	23b. Did to			the cause of death?
Vital Records,	requires /	Completed by							24e. Was a parform		evel	a autopsy findings lable prior to pletion of cause aath?
ital Re	The ate h	60	25. Was casa rafarred to medical					26. Placa of D	1 ☐ Ya		10	Yas 2□ No
	Physician: this certific ral director,	OB	axaminar? 1 ☐ Yes 2 ② No	Hospital:	npatiant 22	ER/Outpatie	ent 3 DOA	Other	Home 5 ☐ Rasida		ar (Specify)	
10	는 무료	n: T	27. Mannar of Death	28a. Data d	of Injury	28b. Tima		Injury at Work?	28d. Dascribe ho			
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	1 Neturel 5 Panding 2 Accident Investigatio 3 Suicida 8 Could not b 4 Homicida	e 28a. Piece	of Injury - At h	oma, farm, si	M treat, factory, of	1 ☐ Yes 2 ☐ No	28f. Location (St City or Town		per or Rural	Routa Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Cartifiar (Check only one) Certifying Property 2 Medical Exer	niner: On tha be	best of my kno esis of axamina ear stated.	owledge, deel ation and/or in	th occurred et the	na tima, dete and place my oplnion, deeth occ	ce, end dua to tha co curred et tha time, d	ausa(s) and mo ata and place,	anner as ste and dua to t	ted. ha cause(a)
	With To t	M	29b. Signatura and titla of certifiar	lon or	2		0	cansa number	2	9d. Data aigne	d (Month, D	ay, Year)
			30. Nama and addrass of person who	~ 5	503 0	utchn		me East	on no	2160/		
	Sta	-	31. Data filed (Month, Day, Year)	000 32. F	ogistrar's Sign	Lar Ron	6.11					

MAR 2 0 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Carol Lee Cyr March 16, 2.48 /Medical 4a. Facility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 14407 Capt. John Smith Drive Prince George Accokeek 5. Social Security Number If Under 1 Yaar | If Undar 24 Hrs. Birthpiace (State or Foreign Country)
 Maine 8. Date of Birth (Month, Dey, May 20, 7. Age (In yrs. last birthdey) **Funeral** 1 □ M 2 X F Months Days Hours 60 Yrs. 004-36-3746 Director Usual Residenca of Decedent filed within 72 hours after death with the Maryland 10a. Stete 10b. County 7 is marked other than "naturel", or items 23s or 28s-f ahow traumatic event, he Magical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director Maryland Prince George Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14407 Capt. John Smith Drive 20607 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No if Yes, Give Year or Dates: 13. Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, atc. 1 □ Never Married 2 □ Merried 21215-0020 1 ☐ Yas 2 ☑ No Specify: Completed by 3 Widowed 4 □ Divorced Specify: White 15. Decadent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Bus Driver Board Of Education it of Haalth and Mantal Hygin If Item 27 is marked other or other traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be Donald H. Shorey Dorothy Knight 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) David C. Cyr Son 6881 Kangaroo Dr., Waldorf, Md. 20603 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) March 17, 1998 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ACremation 3 Removal from State Department of Important: If any Injury or Alexandria, Virginia Metropolitan Funeral Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licenses Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Md. 20640 23e. Part1. Enturing issease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or have failure. List only one causa on each line. Approximate Interval Between Onset end Deeth **Physician** RIAN CARCINDA /Medical Immediete Ceuse (Final diseesa or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thei initiated events resulting in deeth) Lest bunial-tra Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, attanding physician Physician/Medical tha Dua to (or es a consequence of) usa as ata has been signed by tha a paga 2 should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? Aftar this cartificata 1 ☐ Yes SINNO 1 Yes 2000 Hospital or Attending Physician: director. 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA filled in by tha funaral 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Matural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours al To the Funeral C completaly filled edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and menner as steted. 2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and pieca, and the rime as a total.

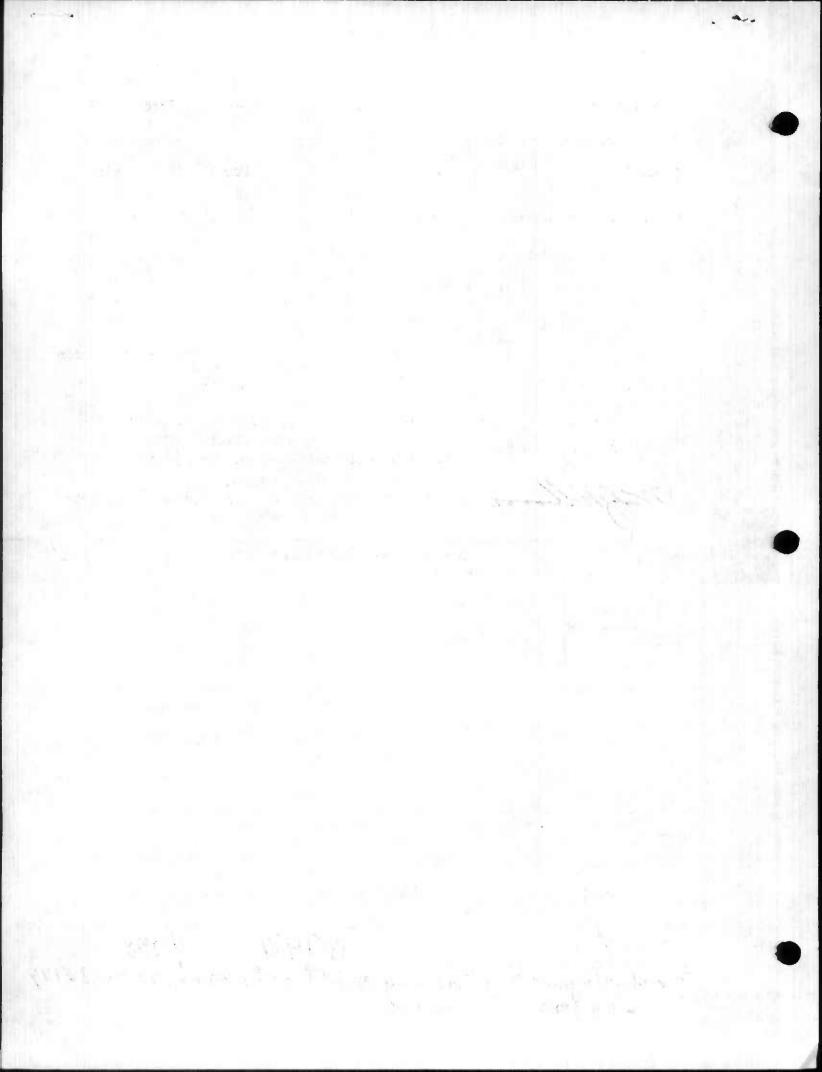
2 medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and pieca, and due to the cause(s) and mennar stated. 29b. Signetura and little of ceptifie 29d. Data signed (Month, Day, Year) gereon who completed cause of deeth (Item 23e) (Type, Print) 30. Name and address of Degistres Signeture 31. Dete filed (Month, Dey, Year State

DHMH 16 Bay 6/95

Registrar

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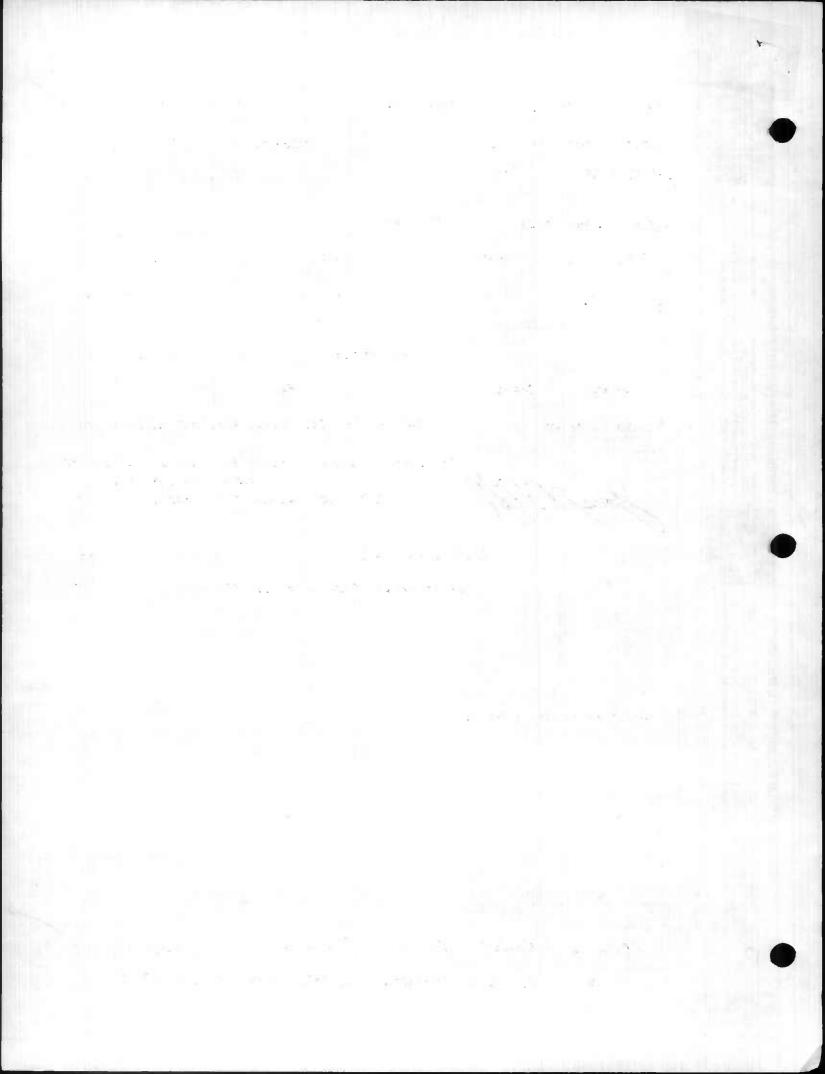
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

					State of Ivi	aryıar				Death		Reg. No.	8	100	11
П	Dhysisia		1. Decedent's Name (First, Midd								2. Date of De Month	eath Day	Y	ear	ma of Death
	Physicia /Medica			mult		Cau	lfield	l .			March				30 P.M.
A	Examine	er	4a Facility Name (If not institution	on, give :	street end number)					4b. City, Town, or	Location of Deat	h 4c. C	ounty of	Death	
1_			Spring Hous 5. Social Security Number			a /la um	In at hirth day	If Lind	er 1 Year	Bethesda If Under 24 Hrs.	9 Date of Bir	Mon	ntgo	mery	to to as Foreign
	Funeral Director		578-62-4135 Usuel Residence of Dacedent	6. Sex	M SEXF	89	lest birthday) Yrs.	Month		Hours Min.					
	land tand		10a. State 10b. Count	У		10c. Cit	ty, Town or Lo	ocation						10d. Insi	de City Limits
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	r 28s	Director	10e. Street and Number	gome	. L y				ip Code			10g. Citize	n of Whe	et Country?	
	th wit		1 E. Lenox		Street				2081	5		11	S.A		
020	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or flerns 23a or 28a-f show ont, the Medical Example, must be notified at	by Funeral	11. Maritel Stalus 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried	12. Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:		lispanic Origin? (S an, Mexican, Puert	in? (Specify Yes or No- Puerto Rican, etc.)		14. Race - American Ir Black, White, etc. Specify: White		an,
Baltimore, Maryland 21215-0020	be filed within 72 hours aft tal Hygiene. d other than "naturel", or event, the Medical Exper-	Completed by	15. Decede (Specify only high Elemantary/Secondary (0-12)	nt's Edu	e com <i>pleted)</i> College (1-4or 5	i+)	16a. Decedent's Usual Occupetion (Giva kind of work done during most life. DO NOT use retired)			during most of wor	king			ness/Industry	
d 2	Hygie ther int, II	ပ္	17. Father's Name (First, Middle	Last)	2		Но	usew:	lre	18. Mother's Nar	na (First, Middle		Home		
an	2 = 0 >	To Be	Joseph	,	Tumulty								,		
37	d 2 should th and Men 7 ie marke traumatic	ř	19a. Informant's Neme/Raietion	ship (Ty			19b. Maili	ng Addre	ss (Street	Mary and Number or Au	Byri Iral Route Numb		Town, St	ate, Zip Code)	
Ž	5 # Z #		Alicia C. Br	OWD			3021	- 4	5th S	t., N.W.	. Washi	noton.	D. 0	C. 2001	6
more,	80 = 5		20e. Method of Disposition 1X Phrial 2 Cremation 4 Donation 5 Othar (3 □R	lemoval from State	4	Plece of Disponentery, cre	osition (N ma <i>tory</i> o	ame of other pla		Dete	20c. Loca	ation - Cit	ty or Town, Sta	ate
alti	ermit. Pa bepartmen mportant: ny injury 8058.		21. Signature of Fundral Service	License	000	7				es of Facility	DeVol F				ICI &
m	89188		2222 Wisc. Avenue, N.W., Wash. D.C. 20007												
	Physician		23a Pun Enter the diseese, or heart failure. Lis	r compli t only or	ications that ceused na cause on each li	the deel	th. Do not en	ter the m	ode of dyi	ng, such as cerdia	or respiretory	errest,		Appro	ximate al Between and Death
	/Medical Examiner		Immedieta Cause (Final disease or condition rasulting In death)	•	. Ca:		c Arry							Imme	diate
	D .=	ner												Years	
Ć,	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury	1	D		or as a conse								
68760,	E 0 6	edical	Cause (Disease or Injury that Initieted events resulting in death) Last	í	Due to (or as e consequanca of):										
Box	death certifi e attending ed for use as	آ §			1										
	0 0 0	Sicia	Part II. Other significant condit	ions con	tributing to death b	ut not ras	sulting in tha u	ındarlying	ceusa gi	ven in Part I.	23b. Did	tobacco u	se contr	ibute to the ca	suse of death?
s, P.0	E 9 D	by Physician/M	Cerebrovas	cula	r Diseas	2					1□	Yes A	(No 3	Probably	4 🗆 Unknowi
of Vital Record	law requires as been sign s 2 should be	Completed				-						s en eutops ormed?	у	24b. Were auto evailable completio of death?	prior to in of cause
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ta	ician: The	Be	25. Was cese referred to medic examiner?	al						26. Place of De	ath (Check only	one)			
>	0 0	0	1 ☐ Yes 2 No	F	lospital: 1 Inpatie	ent 2	ER/Outpatie	nt 3 🗆 I	OOA Ot	her: 4 Nursing I	lome 5 Res	idence 6	Other	(Specity)	
	Attending Ph ar death. ector: After th by the funeral		E CE PROGRAMIC	igation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	M	28c. Inju Wo	nyat rk? ∣Yes 2 □ No	28d. Describe	how injury	occurred		
Division	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Certification:	3 Suicide 6 Could 4 Homicida detar	not be mined	28e. Place of Inj building, at			reet, fact	ory, office			(Straet and wn, State)	Number	or Aural Aoute	e Number,
	n 24 hours n 24 hours ne Funeral pletaly filled	edical	29a. Certifiar (Check only one) 1 Certify 2 Medica	ng Phya i Examir	nician: To the best ner: On the basis of and manner st	examina	owledge, daat ation and/or in	h occurra vastigation	d at tha ti on, in my	ma, data and piace opinion, daath occu	, and dua to the irred at the time	causa(s) a , date and p	nd mann lace, and	nar as stated. d due to the ca	nuse(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certific		1 1			2	_	se number		29d. Dete	signed (Month, Day, Y	ear)
	10	-			lalon,		1. D.	Print\	Da	3127		Marc	ch 14	4, 1998	
			30. Nama and address of parson Kevin G. Neal						#	925 Chev	Chase	, MD 2	20815	5	
	State	e	31. Date filed (Month, Day, Year		#2_Regists	ar's Signa	styre								
	Registra		MAD 18 10		Greek Day	ridron	-Banda B	2							



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth **Physician** MAR. 16, 1998 RUTH В. COAKLEY 9:22 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** ROCKVILLE MONTGOMERY CO. NATIONAL LUTHERAN HOME 5. Sociel Security Number 7. Age (In yrs. lest birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) **Funeral** Birthpieca (State or Foreign Country) Months Days Hours 1 M 2 F 212-09-3690 84 Yrs. Director MAR. 1, 1914 MARYLAND Usuel Residence of Decedent death with the Maryland 10e. Stete 10b. County BALTIMORE CO. 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show MD. CATONSVILLE Director 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 116- OSBORNE AVE. 21228 USA Funerai 12. Wes Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes ≥ 2 No if Yes, Give Year or Detes: Herne 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indien, Bleck, White, etc. The Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mentel Hygiene. 1 Never Married 2 Married 21215-0020 ŏ Be Completed by 1 ☐ Yes 2 No Specify: Specify: WHITE 3X Widowed 4 ☐ Divorced 'netural' 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER AT HOME other 1 Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) is marked of ADELINE M. TWELBECK J. HENRY BENSEN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Heelth a: If Item 27 is REV. DR. REICHARD-EXECUTOR-9701- VEIRS DRIVE, ROCKVILLE, MD. 20850 other 1 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 0 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Depertment of Important: If any injury or once. LAKE VIEW MEM. PARK 3/18/98-SYKESVILLE, MD. 21. Signeture of Funeral Servica Licansee 22. Name and Address of Fecility HYSONG CO., INC. FUNERAL HOME 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. Approximete Intervei Betw Onset and Deeth Physician /Medical immediate Ceuse (Finel 1 weeks diseese or condition resulting in deeth) newo Due to (or es e consequence of): neumon **Examiner** Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest tha buriel-tran P.O. Box 68760, ettending physician for use as tha burie in Physician/Medicai Due to (or es e conseguenca of) ed by the el detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? certificate hes 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA this in by the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of Aftart 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 ⊟tNeturei death. 1 Yes 2 No 2 Accident efter death 3 Suicide 6 Could not be 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 THomicide To the Hospital
within 24 hours
To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29e. Certifier 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) winn - mo 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) DR. C. SCHEMM- 9701- VEIRS DR., ROCKVILLE, MD. 31. Dete filed (Month, Day, Year) 32 Registrar's Signeture State Registrar MAR 18 1

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Rebecca Jean Collins March 19,1998 tion of Death 4c. County of Deeth /Medical 2:46 AM 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** The Memorial Hospital Easton If Under 24 Hrs. 8. Talbot Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 07/06/41 Birthplaca (Stete or Foreign Country) 5. Social Security Number **Funeral** 1□M 2⊠F Months Days Hours Min. 56 Yrs. 212-40-8445 Director Delaware Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23s or 28s-f shov solical Examiner must be notified at MD Caroline Federalsburg 1 ☐ Yes 2 No Director 10e. Street and Number 24541 Hynson Road 10g. Citizen of What Country? 10f. Zip Code 21632 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. 1 ☐ Never Married 2 점 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic avent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry merked other than College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Elmer F. Jester, Sr. Mary Jane Lane 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shr Department of Health and Important: If Item 27 Is m any Injury or other traum once. Robert A. Collins/Husband 24541 Hynson Road, Federalsburg, MD 21632 20a. Method of Disposition

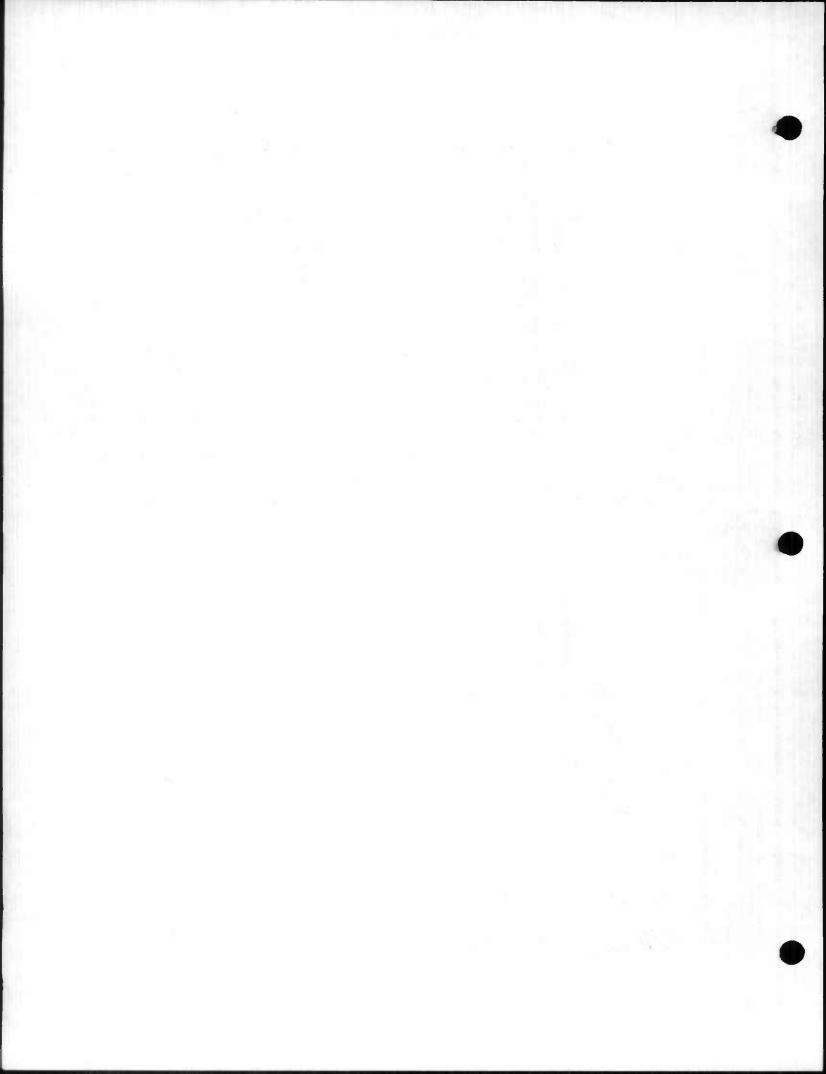
ABBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State Hill Crest Cemetery 3/21/98 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral Home, P.A Eskow PO Box 43, Federalsburg, MD 21632 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final sino DNeumonia diseese or condition resulting in death) Examiner Physician/Medical Examiner LUNG the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Due to (or as e consequence of) 950 P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detech-Chronic Stenord Lose 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by pulmonale 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Hypothyoidism completion of cause of death? page 2 obesit 2 No this certificate of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No Certification: To To the Mosphan after deeth.

Within 24 hours after deeth.

To the Funeral Director: After this 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the st 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Xla ae 6 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 219 South Washington St., Easton, MD 21601 Michael Lees, M.D. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAR 2 0 Registrar a waydoon-Handall

DHMH 16 Bay 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** Paul De Leeuw Mar 14,1998 08:40am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Silver Spring Holy Cross Hospital Montgomery If Undar 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (Steta or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 70 1927 Netherlands Director 079-34-3521 Nov. Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itams 23a or 28a-f sho other traumatic event, the Medical Examiner must be inclined at 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Kensington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20895 3000 McComas Avenue United States Funeral Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - Americen Indian, Black, White, etc. 1 ☐ Yes 2 No If Yas, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Sacondary (0-12) Collaga (1-4or 5+) Music Coach Music permit. Pages 1 end 2 should be flie Depertment of Health end Mental Hy Important: If Item 27 I a marked oths any Injury or other traumatic event once. 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be De Leeuw Henry Rachel Souhami 2 19b. Meiling Address (Street end Number or Rural Routa Numbar, City or Town, Stete, Zip Coda) #122719a. Informent's Name/Ralationship (Type, Print) 3001 Veazey Terrace, NW, Washington, DC De Leeuw /brother 20b. Piece of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriai 2 ☐XCremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 3-19-98 Beltsville, Maryland 22. Nama and Address of Fecility
Rapp Funeral Services, P. A. 21. Signeture of Funeral Service Licenses 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heert failure. List *on*ly one ceusa on eech line. 933 Gist Avenue, Silver Spring, MD 20910 Approximata Intervel Between Onset and Death **Physician** immediete Ceuse (Finel disaase or condition resulting in deeth) cardial infaction /Medicai Examiner Due to (or es e consequence of) Physician/Medical Examiner The lew requires that the death certificete be executed attending physician and for use es the buriel-tran Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disaase or injury Due to (or es e consequence of). Records, P.O. Box 68760, that initiated events resulting in deeth) Last Due to (or es a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? gestive Reart failure 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy page 2 this certificate hes 1. Yas 2 No 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

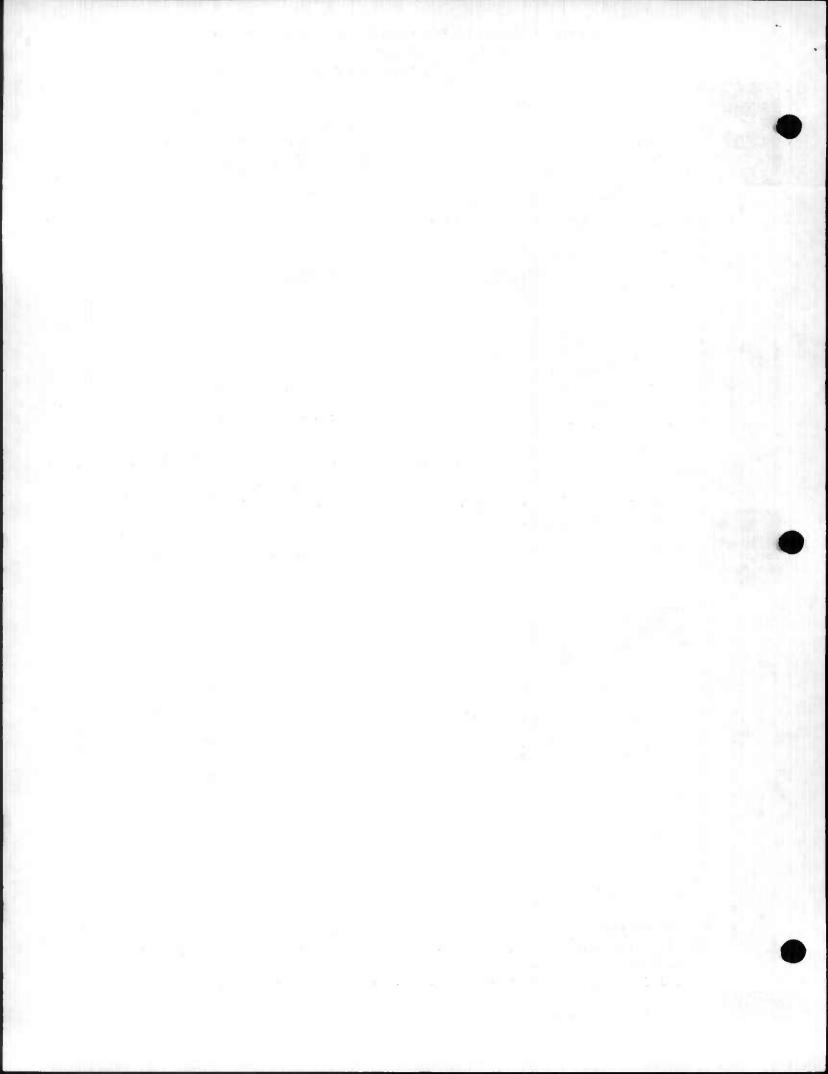
To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Wes cese rafarrad to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient edicai Certification: To 2 ER/Outpetient 3 DOA 27. Menner of Daeth 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturei 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Spacify) 4 Homicide 1 Cartifying Physician: To the best of my knowladga, death occurred et tha tima, data and place, and due to the ceuse(s) end mannar as statad.
2 Medical Examinar: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et tha tima, data and place, end due to the ceuse(s) and menner steted. 29a. Certifier (Check only 29b. Signatura and file of certifier 29d. Date signed (Month, Day, Year) 29c. License number 03/18/98 30. Name end addrass of person who completed ceusa of daath (Item 23e) (Typa, Print) David A Blass Md 9410 Old georgetown rd Bethesda Md 20814 31. Data filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

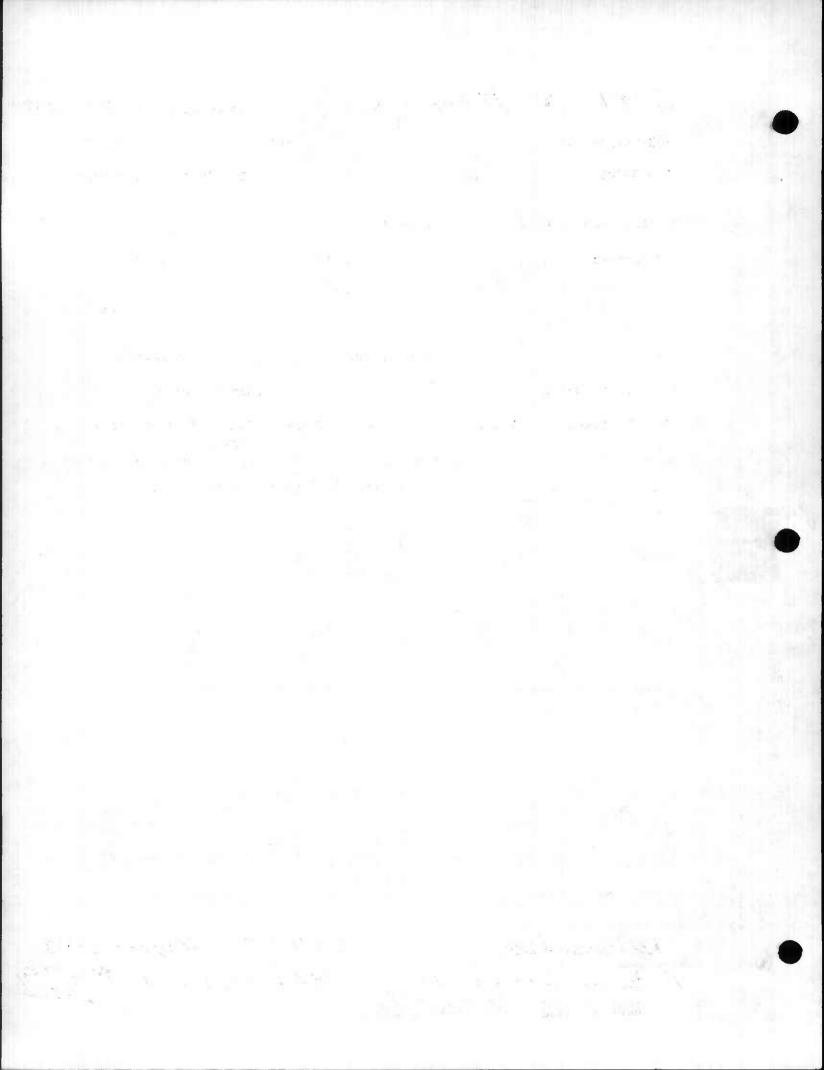
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a Davidson



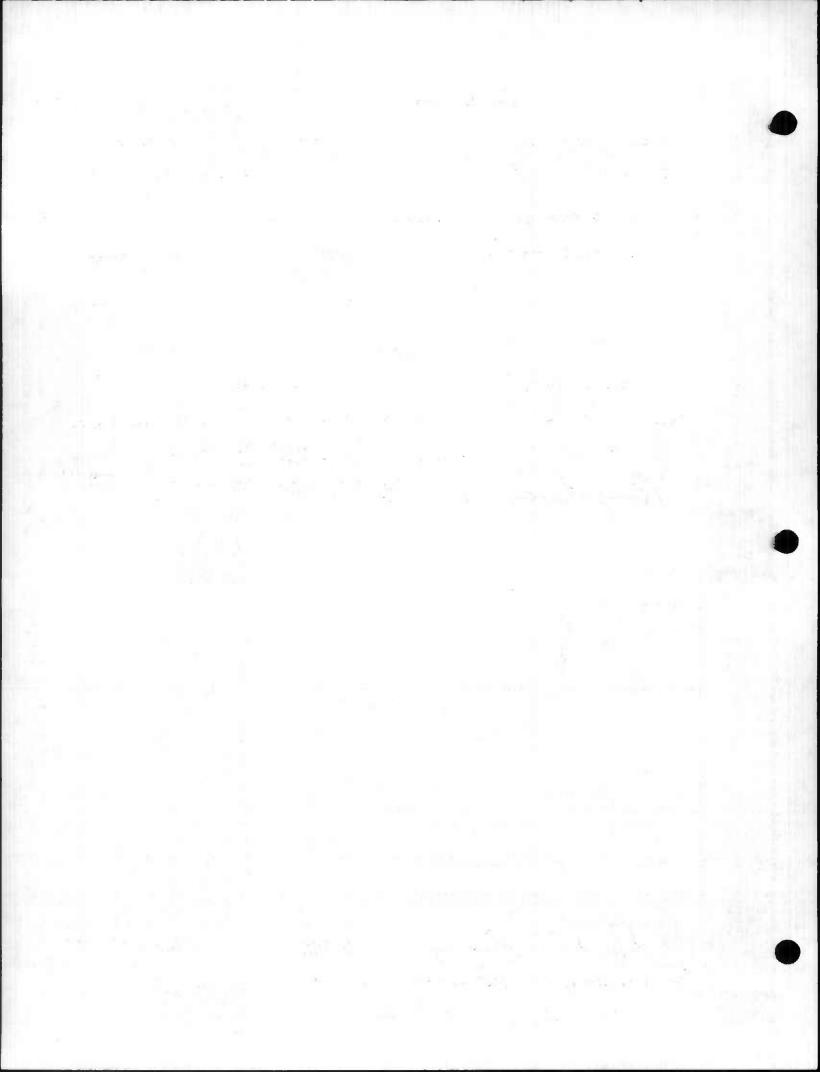
State of Maryland / Department of Health and Mental Hygiene

						Certific	ate of	Death		Reg. No.) [010
	Physic /Med		1. Decedent's Neme (First, Middle, Las	M. D'An	16	vos.	101		2. Dete of Dec Month	eth Dey	1998	3. Time of Death
	Exami		4e. Fecility Neme (If not Institution, give	e street end number)				4b. City, Town, o	r Location of Deeth	4c. Count	y of Deeth Arund	21
	Funeral Director		5. Sociel Security Number 6. S			thday) If Un Monti	der 1 Yea hs Deys	r If Under 24 Hr		h y, <i>Year)</i>		eca (Stete or Foreign ry)
	e Maryland	ctor	10a. Stete 10b. County Maryland Anne Art			n or Location					10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	72 hours after death with the Manyland natural; or items 23a or 28a-f show ocal Examiner must be notified at	Funeral Director	10e. Street end Number 103 Mariner Court 11. Maritel Stetus			10f.	Zip Code 210 cedent of		U.S.A.			n indien,
7020	ours afte rai', or it Examin	by	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:			2 ⊠ No		nto riioan, otc.)	Specia	ock, White, e fy: Whil	
0200-61212	within ene. than	Completed	15. Decedent's Ed (Specify only highest green Elementery/Secondery (0-12)	lucation de com <i>pleted)</i> College (1-4or 5+)			work done Tuse retin	pation during most of w ed)	orking	16b. Kind of E	Business/Inde	ustry
	be filed ital Hyg d other event,	To Be C	17. Fether's Neme (First, Middle, Last)		ье	auticia	an		eme (First, Middle,	Meiden Sumer	tology	/
Maryland	d 2 sh th and 7 is m traum	-	Major Scott Burke 19e. Intorment's Neme/Reletionship (7	Type, Print)				t end Number or F	Ssie And Rurel Route Numbe	er, City or Town		
parimore,	Peges 1 and 3 nent of Health of: If Item 27 iny or other tr		Joan M. Baker 20e. Method ot Disposition 1 ⊈Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Removei from State	Piece of cemeter	Disposition (/ y, cremetory o	Veme of or other pla	эсө)	Takoma 3/18/98	20c. Location	- City or Tow	m, Stete
Dair	permit. Peg Department important: I any injury c		21. Signeture of Funerel Servica Licans	was	311_111;	22. Neme Franc:	and Addr		Funeral		Inc.	
ı	hysician		snock, or neer tellure. List only o			ot enter the m	ode ot dy	ing, such es cardie		rest,		Approximete Intervel Between Onset end Deeth
	/Medical Examiner	er	Immediate Cause (Finei disease or condition resulting in deeth)	e perpusation of Due to (c	A O	P ve	es (uleu	der	lare		lears
'n	icate be executed physician and s the buriel-transit	Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (c	or es e c	consequence's	M	elli			3	Hours
	ding se es	/Medical	Cause (Disease or Injury that Initiated events resulting In deeth) Lest	Due to (d	or es e c	onsequenca o	():	·			0	
	t the death of by the ettern eched for us	Physician	Pert II. Other significant conditions co	ntributing to death but not res	uiting In	the underlying	g cause gi	ven in Pert I.	23b. Dld t	obacco une co	ontribute to t	the cause of death?
	es ma igned be del	by							101			ably 4 ☐ Unknown
	2 S B	Completed							24e. Wes e perfor	med?	com	e autopsy findings lable prior to pietion ot cause eath?
	ysician: The tis contificate he director, page	Be Co	25. Wes case referred to medical exeminer?						1 ☐ Y		10	Yes 2□ No
	E = E	ition: To	1 Yes 2 No 27. Menner of Deeth 10 Neturel 5 Pending 2 Accident investigation	Hospitei: 1 Inpatient 2 Inpatient 2 (Month, Dey Year)	ER/Out 28b. Ti		28c. Inju Wo		Home 5 Resid		1-1-1-27	
	= 5 = 6	Certification:	3 Suicide 6 Could not be determined	28e. Pieca of Injury - At he building, etc. (Specification)	ome, ter	m, street, tact			28f. Location (S City or Tow		ber or Rural i	Poute Number,
	within 24 hours of To the Funeral Completely filled	edical	29a. Certifier (Check only one) (Check only one) (2 Medical Exami	elclan: To the best of my kno ner: On the basis of examine end menner steted.	wiedge, tion end	deeth occurre /or Investigetion	ed et the ti on, in my d	me, dete end piec opinion, deeth occ	a, end due to the curred et the time, d	euse(s) and mo lete and plece,	enner es stat and due to t	ted. he cause(s)
1.0	Tot	2	29b. Signeture end title of certifier **RUSCISU **TOTAL CONTROL CONT	least				se number 3-15-7		9d. Dete signe MARA		
10)		30. Name and address of person who co	empieted cause of deeth (Item	23e) (T	Type, Print)	1/2	Rel A	Mes A ou	0, 0	21 81	1888 West Ct
	Sta	ite	31. Dete tiled (Month, Dey, Year) MAD 18 100	32 Registrar's Signa	ture %	ladies.			700			210%



State of Maryland / Department of Health and Mental Hygiene

						Certif	icate of	Death	F	leg. No.	10	UT	O
	Physic	lon	1. Decedent's Name (First, Middle, L.						2. Date of Dee Month		Year		e of Death
	/Medi			Betsy P. 1	Jav1s				March	12, 19	98	12:0	00 PM
):	Exami		4e. Fecility Name (If not institution, gi	ve street and number)				4b. City, Town, or	ocation of Death	4c. County	of Deeth		
			Manor Care-Poto					Potomac			gomer		
. 1	Funeral Director			Sex 7. Age (In ,	yrs. last bi 72		Under 1 Year onths Days		8. Date of Birth (Month, Day Aug. 18	, Year)		lace (Stat itry) ginia	te o <i>r For</i> aign
1215-0020 within 72 hours efter deeth with the Meryland	-f show	tor	10a. Stete 10b. County Maryland Montgot	_		n or Location	on				1		e City Limits
the	7.288	Director	10e. Street and Number				Of. Zip Coda			log. Citizen of t	Whet Coun	ntry?	
h with	38 0	0 18	10714 Potomac Te	nnis Lane			208	54		United			
deet	E E	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S.	13. Wes	Decedent of	Hispenic Origin? (S oan, Mexicen, Puert	pecify Yes or No-	14. Rac	e - Americ	en Indian	P
020 urs efter	t of Health and Mentel thygiene. If Rem 27 Is marked other than "natural", or items 23s or 28s-f show or other traumstic event, the Modical Examiner must be nortified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Yes 2 No		o Mican, etc.)	Specif	ck, White, y: T	_{White}	
5-0 72 %	netur Isal	ted	15. Decedent's E (Specify only highest gr	ducetion	16e	. Decedent	s Usual Occu	pation	t la a	16b. Kind of B			
Z light	en "	Completed	Elamantary/Sacondary (0-12)	College (1-4or 5+)		life. DO	VOT use retire	during most of wor	King				
filed w	ygien Arth	S	12		1	Mode1				Fashi			
	d oth	Be	17. Father's Name (First, Middle, Las	'					ne (First, Middle,	Maiden Suman	ne)		
arylan should be	Mer Brico	2	Joseph Smith Po					Lola W					
Z Sp	Is m		19a. Informant's Name/Relationship	****				t and Number or Ru					
l end	Healt om 27 ther		Larry J. Hughes/		L Disease	4 Pilesenhie	- 101	ker Road,	- 17				
Baltimore, Maryland 21215-0020	5#5		1 ☐ Buriai 2 ☒ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spaci	Removal from State	cemete	ry, cremato	ry or other pla	March I	.3, 1998 nc.	ethesda			
Balti	Depart Import any inj		21. Signature of Funeral Service Lice	00 3 H1620	198	22. Na Robe 75.	me and Addr 2rt A. 57 Wise	Pumphrey	Funeral	Home/	Chas	sda-C	hevy nc.
Ph	ysician		23a. Pert1. Enter the disease, or con shock, or haan failure. List only	plications thet ceused the done cause on each line.	laeth. Do	not enter th	e mode of dy	, Marylan ing, such es cardled	d 20814 or respiratory arr	-3501 est,		Approximintervat E Onset an	Between
//	Medical		Immediata Cause (Final disease or condition	Lung	Canc	pr					į	Year	î.c
Ex	aminer		resulting in death)	а.	1111	consequen	ce of):					leal	.5
P	25	ner	_		,	11.					1		
U, e execute	ian end uriel-trans	Examiner											
I DECOLOS, P.O. BOX 06/00, The law requires that the death certificate be executed	ettending physician end for use as the buriel-transit	n/Medical	that initiated evants resulting in death) Last	Due to	o (or as a	consequenc	ce of):				1		
O. DO.	ed by the ettendin deteched for use	Physician/	Part II. Other significant conditions of	ontributing to death but not	resulting is	n the under	lying ceuse gi	ven in Part I.	23b. Did to	bacco use co	ntribute to	the caus	e of death?
S, T.O	5.8	by Ph	Multiple Sc.	lerosis					1 🗆 Y	es 2□ No	3 □ Prot	pably ©	⊠ Unknow n
necords,	s been s 2 should	Completed							24a. Was a perfor	n autopsy med?	ava	ere autops ailable pric mpletion o death?	sy findings or to of ceuse
	pa at	Co							1 □ Y	as 2 No	1 🗆	Yes 2	□ No
VILLE	s certificate director, pag	Be	25. Was cese referred to medical axaminer?	Manager					th (Check only or	e)			
o layer	this o	10	1 ☐ Yes 2 ☒ No		ER/O		L DON		ome 5 Reside			1)	
LIVISION OF	or: After	ation	27. Mannar of Death 1 ☒ Natural 5 ☐ Panding 2 ☐ Accident Investigatio		286.	Fima of njury	28c. Inju Wo и 1□	ryal rk? IYes 2 □ No	28d. Describe ho	w Injury occur	red		
al or Am	M Direct	Certification:	3 Suicide 6 Could not b 4 Homicide datarminad	28a. Place of Injury - A building, etc. (Spe	t home, fa	rm, street,	factory, office		281. Location (Si City or Town		er or Rura	Route N	umber,
To the Hospital or Attending Physician:	within 24 hours eller deem. To the Funeral Director: After thi completely filled in by the funeral	edicai (29a. Certifiar (Check only one) 1 ☑ Certifying Ph	ysician: To the best of my inner: On the basis of exam and manner stated.	knowledge ination an	, death occ d/or Investi	urred at the tigation, in my o	me, data and place opinion, death occur	and due to the cored at tha tima, d	ause(s) and ma ate and place,	nner as st and dua lo	ated. the cause	9(s)
To th	Toth	X	29b. Signeture and title of certifier	200	-		29c. Licens	se number	2	9d. Dete signe	d (Month, L	Day, Year,)
6			Havil (1. Han	yon		023	1911		March	12.	1998	?
Ψ			30. Nama and address of person who	4		Type, Print	-	1.1		127		, , ,	
			David A. Blass, M	I.D. 5480 Wi	scons	sin Av	enue,	Chevy Cha	ase, Mar	yland	20815)	
	Sta Registra		31. Data filed (Month, Day, Year) MAR 16 199	32 Registrar's Signal David	gnature	notess							



		Co	ertificate of	Death		leg. No.	100	
1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	Day	Year	Time of Death
Dorothy J. DeCa					March 1	1		:00 PM_
4a Facility Name (If not institution, go	ve street end number	r)		4b. City, Town, or	Location of Deeth	4c. County	of Death	
Montgomery Gene			ارس) If Under 1 Year	Olney If Under 24 Hrs	0 Data -(D) 41	Montg	omery	10: 1 5
	Sex 7. A 1 M 2 TF	ge (In yrs. last birthda Yrs.	Months Days	Hours Min.	(Month, De)	, Year)		(Stete or Foreign
125-10-5276 Usual Residence of Decedent		80 113.			Sep. 21	,1917	New Yo	rk
10a. Stete 10b. County		10c. City, Town or	Location				10d. le	nside City Limits
Maryland Montgo		Cd lane as 1					1	☐ Yes 2 No
Maryland Montgo	mery	Silver	10f. Zip Code		1	I 0g. Citizen of V	Vhat Country?	
3334 Chiswick Co	rt		201	906			U.S.A	٨
11. Marital Status	12. Was Deceden	t Ever in U,S. 13	. Was Decedent of I	Hispanic Origin? (S	pecify Yes or No-		e - Americen In	
1 ☐ Never Married 2 ☐ Married	Armed Forces		if Yes, specify Cub		o Mican, etc.)		k, White, etc.	
3 ₩ Widowed 4 Divorced	If Yes, Give T	:	1 ☐ Yes 2 ☑ No	Specify:		Specify	Whit	:e
15. Decedent's E (Specify only highest go	Education rede completed)	16a. Dec	edent's Usuai Occur	pation during most of wo	rkina	16b. Kind of Bu	siness/Industr	У
Elementary/Secondary (0-12)	College (1-4or	5+)	ve kind of work done . DO NOT use retire	od)				
	1	Home	emaker		450	Own Ho	The same of the sa	
17. Father's Name (First, Middle, Las	1)			18. Mother's Na	me (First, Middle,	welden Sumen	ie)	
Joseph Campbe				Louis	e Flemi	ng		
19a. informant's Name/Reletionship			iling Address (Stree					,
Dorothy Beck	(daug	nter) 6107	Emmett Gr	uards Cou				
20a. Method of Disposition 1 ☐ Buriel 2 ☒ Cremation 3	Removei from State	cemetery c	remetory or other ple	ce)	Date	20c. Location -	City or rown,	State
4 ☐ Donetion 5 ☐ Other (Spec	ify)		litan Crem		3/18/98	Alexand	ria,Vir	ginia
21. Signeture of Funeral Service Lice	~ / 1 /	1 -	22. Name and Addr rancis J.	0 111	Funeral	Home T	nc	
Inchew	400	(e) ==	00 Univer	sity Blvd	WSil	ver Spr	ing.MD	20901
23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause y one cause on each	ed the death. Do not e	enter the mode of dy	ng, such as cerdie	c or respiretory ar	rest,	App	proximate ervai Between
							Ons	set end Deeth
immediate Cause (Final disease or condition	, [-iver	Failur	2			OA	re week
resulting in death)		Due to (or as a cons	equence of):					
	ne met	astatic	Breast	cance	rtoli	ver	UN	eweek
Sequentially list conditions,		Due to (or as a cons	equence of):					11
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	c. Se	izure	disorde	٢			3.	nonths
that initiated events resulting in deeth) Last		Due to (or as a cons					i	
	d. Meta	static T	Breast	CANCER	+0 (3r	air		
Pert ii. Other significant conditions	contributing to death	but not resulting in the	underlying ceuse g	ven in Part i.		N		causa of death?
					101	res alcuno	3 Probably	y 4 Unknow
					24e. Was	an autopsy	24b. Were a	utopsy findings
						med?	compie	etion of cause
							of deet	
					1 D Y		1 ☐ Ye	s 20-No
25. Was cese referred to medical examiner?	Hospital:		O	her:	eth (Check only o			
1 Yes 2 1040	Hospital: 1 2 inpa		ient 3LI DOA	4 LI Nursing I	dome 5 ☐ Resid			
1. Natural 5 ☐ Pending	(Month, D	ey Year) injun	Wo	ork?]Yes 2 □ No		,,		
3 ☐ Suicide 6 ☐ Could not	be On Pinneti	njury - At home, farm,			28f. Location (S	Street and Numb	er or Rural Ro	ute Number.
4 ☐ Homicide determine	building,	etc. (Specify)			City or Tow	m, Stete)		
(Check only 2 Medical Exa	miner: On the basis	t of my knowledge, de of examination and/or	ath occurred at the ti investigation, in my	ime, dete and place	e, and due to the curred at the time, o	cause(s) end me dete end plece,	enner as stated and due to the	i. ceuse(s)
29a. Certifier (Check only one) 29b. Signature and attention	end menner s	steted.	29c Licen	se number		29d. Dete signe	d (Month Day	Voer)
250. Orginal distribution of Certifier	4.2./	1						
Janes!	1240	19		1190		March	16,14	70
30. Name and address of person who	completed cause of	deeth (item 23e) (Typ	e, Print)					
50. Ivase and address of person with								
J. Garrett Reill 31. Dete filed (Month, Day, Year)		3418 01an	dwood Cou	rt #111	Olney,Ma	ryland	20832	

Anchen J. Cole

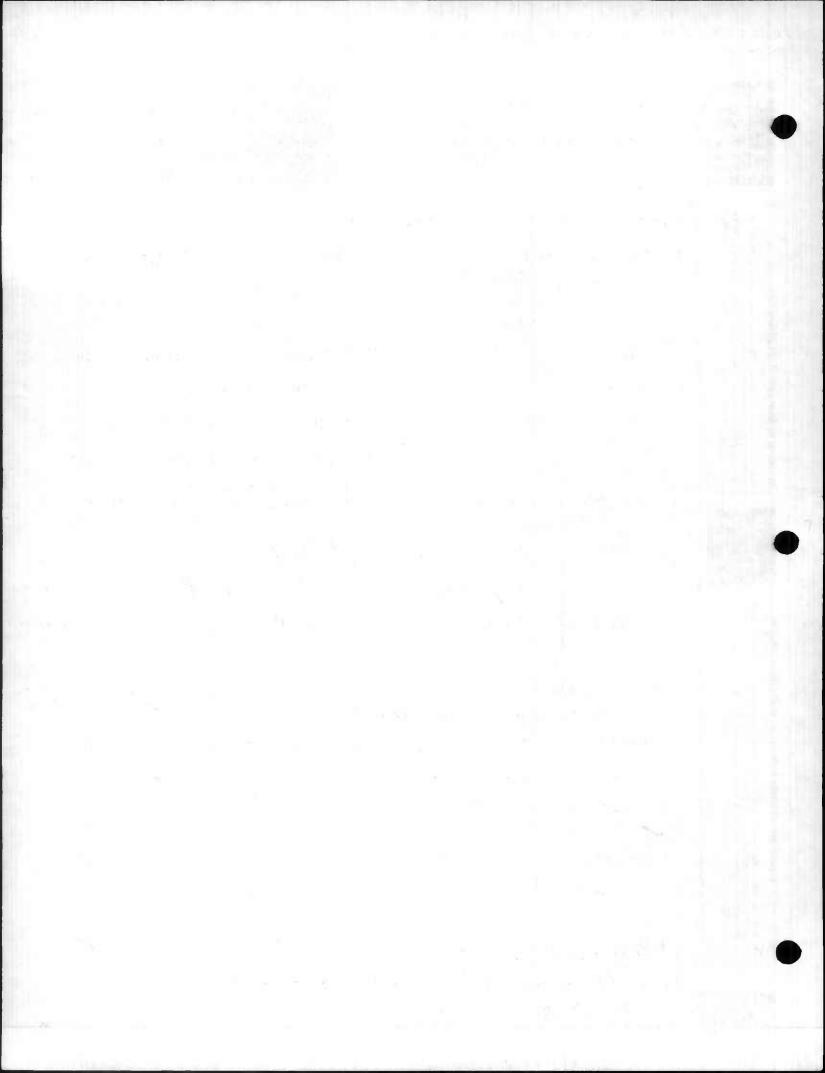
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Dey **Physician** Month Yaar Henry Hugh March 18, 1998 9:02 AM /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01 ne y Montgomery If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) June 18, 1 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 17∕0 M 2 □ F 195-24-0504 81 Yrs Director Pennsylvania Usual Rasidanca of Dacadani Pages 1 end 2 should be filed within 72 hours efter death with the Meryland nent of Health end Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f shore 1 ☐ Yas 2 No Director Maryland Montgomery Silver Spring 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 15024 Westholm Court 20906 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married Married "natural", or 1 Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed marked other than "natur imatic event, the Medical 15. Decedant's Education (Spacify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) CPA / Partner Accounting Firm 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Levi Dembo Eva Winklestein 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Jean Dembo (wife) 15024 Westholm Court, Silver Spring, MD item 27 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, State Department of important: If it any injury or c 1 ABurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 3-20-98 Rockville, Maryland 21. Signatura of Funaral Sarvice Licansaa 22. Name and Addrass of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata interval Batween Onset and Death **Physician** /Medical immediata Ceusa (Final e. Acute respiratory failure
Dua to (or as a consequence of): disaasa or condition rasulting in daath) Examiner Examiner The lew requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, laading to immadieta causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last engistive beint Failure Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Suprahuclear Palsy Completed by Dementia old centhrounsenten accorden 24b. Were autopsy findings aveilabla prior to complation of causa of death? 24a. Was an eutopsy performed? Coronan astern discist 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica 25. Was case referred to madical axeminer? Be 26. Place of Death (Chack only one) Hospital: 1 Inpatlant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 □ Yas 2 □ No 2 Accidant 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital
within 24 hours a
To the Funeral C 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifia Medical 29b. Signatura and titia of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

Wheaken MD 20906

State Registrar 30. Name and eddress of person who completed causa of deeth (Item 23e) (Type, Print)

Mar 19 1938

3929 Ferrara Da



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State of Maryland / Department of Health and Mental Hygiene

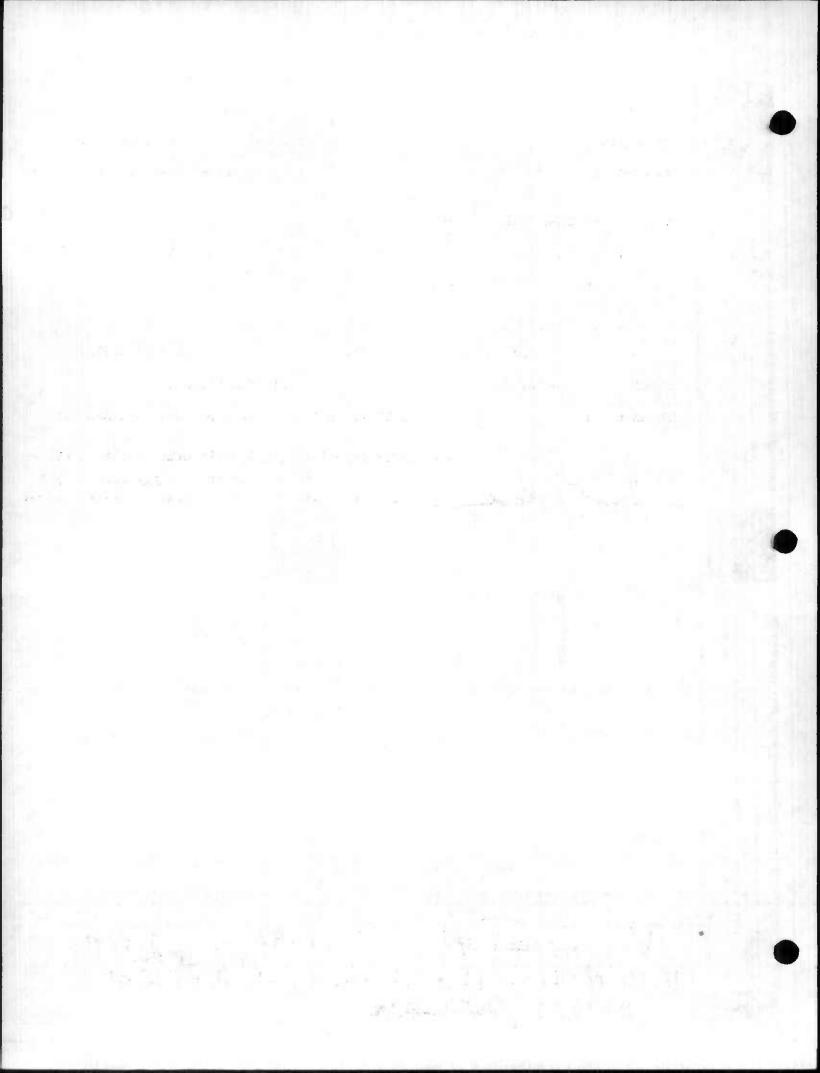
Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Month Yeer PAUL DONATO , 1998 MARCH 1:00P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 923 SHEILA DRIVE GLEN BURNIE ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, JULY 8, 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 9. Birthplece (Stete or Foreign 1⊠M 2□ F Yrs. BROOKLYN, N.Y. 83 Director 123-22-1026 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? b 923 SHEILA DRIVE 21061 U.S.A. thems 23a 12. Wes Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 □ No 1941— If Yes, Give Yeer or Detes: 1945 Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11. Maritel Status filed within 72 hours after 1 ☐ Never Merried 2 Married b Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: à 3 Widowed 4 Divorcad 'natural', Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A TRUCK DRIVER DAIRY INDUSTRY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Pages 1 and 2 should be nent of Health and Mental PASOUALE DONATO MARIA MERIGILIANO 19e. Informent's Neme/Reletionship (Type, Print) Important: If Item 27 is m any injury or other traum once. 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) REGINA DONATO 923 SHEILA DRIVE GLEN BURNIE, MARYLAND 21061 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Doneyon 5 Other (Specify) GLEN HAVEN MEMORIAL PARK 3/11/98 GLEN BURNIE, MARYLAND 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A. 21. Signature Funeral Service Line 1 SECOND AVE., S.W. GLEN BURNIE, MARYLAND 21061 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in death) Examiner Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and hysician and the burial-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Physician/Medical Due to (or es e consequence of) 98 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sate has been signed to pege 2 should be det Records, by Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) Certification: To 1 Yes 2 ZNe 1 Inpatient 2 ER/Outpetient 3 DOA filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled in Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner steted. (Check only one) 29b. Signature and title of certifier 29c. License nymber 29d. Dete signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (ttem 23e) (Type, Print) 6 Ten Bur 31. Dete filed (Month, Dey, Year) MAR 1 0 1998 32 Registrar's Signeture State

ha Daydson

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First, Middla, Last) 2. Data of Death DOYF **Physician** /Medical 4a. Facility Name (If not institution, give street and nymber) City, Town or Location of Death Examiner ARUNDEL HOSPITAL NORTH If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1√ M 2□ F Days Hours 220-05-0595 Yrs. Director JAN. 6, 1921 Usual Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 620 PINE DRIVE Funeral 21122 12. Was Dacadant Evar in U.S. Armed Forcas? 1½] Yas 2 □ No 1942 — If Yes, Giva Yaar or Datas: 1946 Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Stetus 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: þ 3€Widowed 4 Divorced Completed 16e. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) 1 2 Hygiena. Collaga (1-4or 5+)

N/A

16b. Kind of Business/Industry FREIGHT

U.S.A.

17. Fathar's Nama (First, Middla, Last) FENIMORE COOPER DOVE

EDITH VIOLA BASSFORD

19a. Informant's Name/Ralationship (Type, Print)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

CYNTHIA RUTH HOGAN 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☑ Donation 5 ☐ Other (Specify)

620 PINE DRIVE PASADENA, MARYLAND 21122

20b. Place of Disposition (Name of cematary, cramatory or other place)

20c. Location - City or GLEN HAVEN MEMORIAL PARK

TRUCK DRIVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

20c. Location - City or Town, Stata 3/12/98 GLEN BURNIE, MARYLAND

21. Signaturi of Funeral Socice Licens

22. Name and Addrass of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE., S.W. GLEN BURNIE, MARYLAND 21061

18. Mothar's Nama (First, Middle, Maidan Surnama)

Entar tha disaase, on complications that causad tha death. Do not antar tha mode of dying, such es cardiac or respiretory errest, or haert failure. List only one cause on each line.

Approximete Intarval Between Onset and Death

Physician /Medical Examiner

physician end the buriel-transit

signed by the e

peeu

Hospital or Attanding Physician: 24 hours aftar deeth. Funeral Director: After this certific

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

funeral

Box 68760

P.O.

Division of Vital

Examiner

Physiclan/Medical

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Certification:

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Department of Important: If it any injury or o

Peges 1 end 2 should be 1 sent of Health and Mentel I nt: If item 27 is marked of

70

ACUTE MYOCARDIAL INFARCTION

PNEUMONIA

2 DAYS

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated evants rasulting in deeth) Last

Immediata Causa (Final

disaasa or condition rasulting in death)

. METASTATIC PROSTATE CANCER

8-20 Am

ARUNEL

MARYLAND

14. Raca - American Indian, Black, Whita, atc.

Specify: WHITE

Birthplaca (State or Foreign Country)

10d. inside City Limits

1 ☐ Yas 2 ☐ No

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 robably 4 ☐ Unknown

24a. Wes en autopsy performed?

24b. Were eutopsy findings available prior to complation of cause of daath?

26. Placa of Death (Check only ona)

1 ☐ Yas 2 No

25. Was casa raferred to medical axaminar? 1 Yaa 2 No 27. Mannar of Death

5 Panding

Invastigation 6 Could not be datarmined

1 Natural

2 Accident

3 Suicida

1 patient 2 ER/Outpatient 3 DOA

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how Injury occurred

28e. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 4 Homicida 1/A Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signatura and titia of certifiar

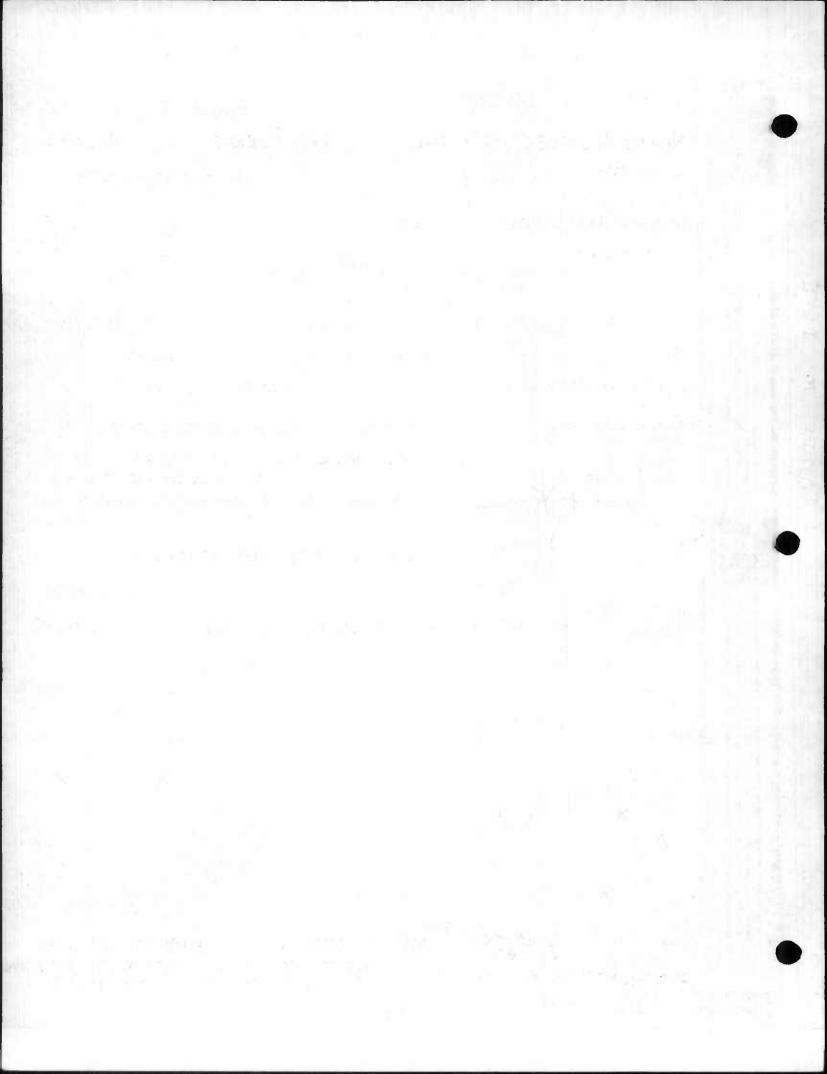
House. 29c. Licensa number officer D51664

29d. Data signed (Month, Day, Year) MARCH 08 1998

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) NORTH ARUNDEL HOSPITAL, 301 HOSPITAL SUDHIR KUMAR AGGARWAL DRIVE, GLENBURNIE, MD 21061

State Registrar

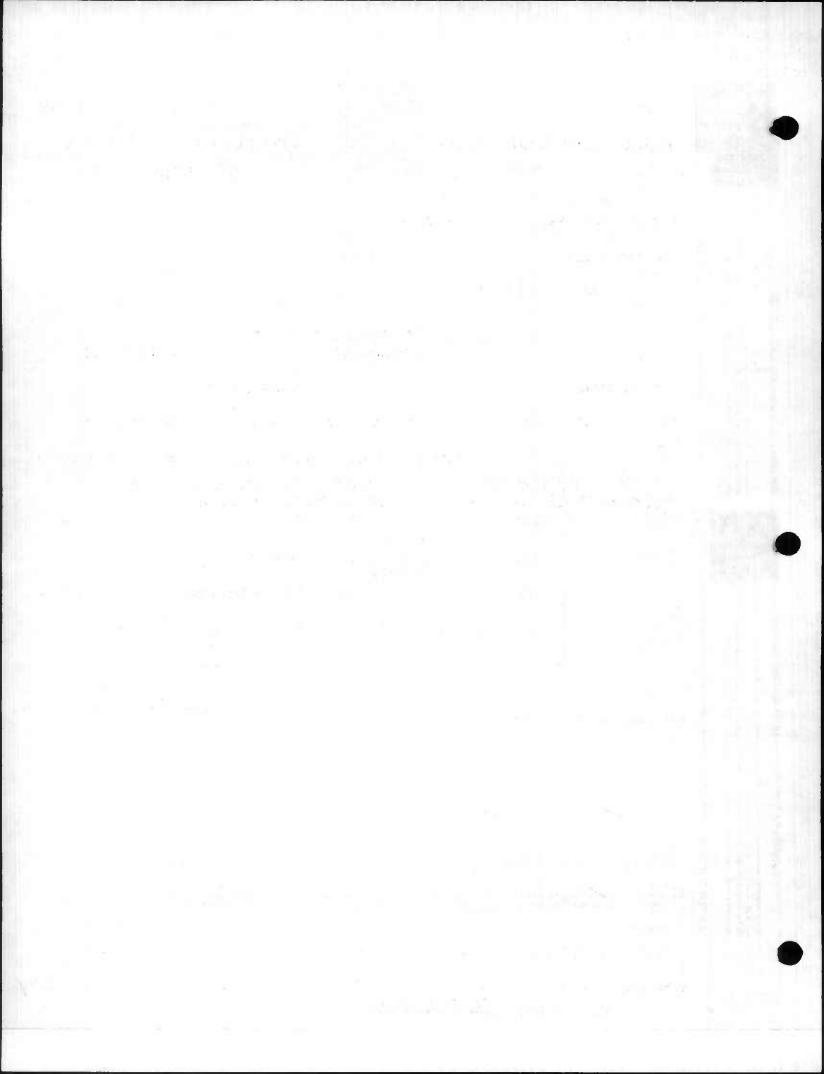
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State of Maryland / Department of Health and Mental Hygiene

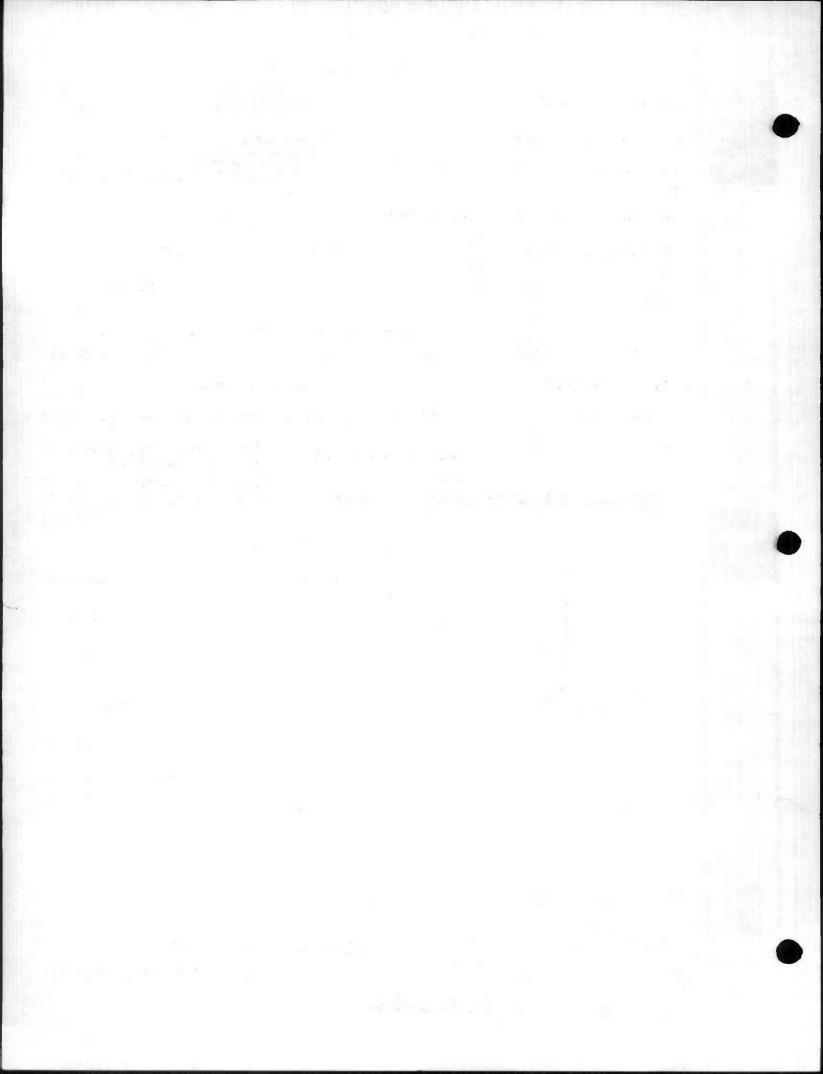
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Funera			Sex 7. A 1 M 2 X F	ge (In yrs. lest i	Yrs.	If Under 1 Year Months Days		Min.	8. Dete of Bir (Month, De	ne of Birth (State or F. Country) NE 12,1932 Sirthplece (State or F. Country) KENTUCKY		
Directo		Usual Residence of Decedent		65					JUNE 1	12,1932	KEN	TUCKI
ylend		10a. State 10b. County		10c. City, To	wn or Loc	cation						10d. Inside City Limits
Mar Mar	ctor	MARYLAND DORCHES	STER	CAMBR	IDGE							1 X Yes 2 No
or 28	Director	10e. Street end Number				10f. Zip Code				10g. Citizen o	f What Cou	intry?
23a		1708 RACE STREET				21613				USA		
or des	Funeral	11. Maritel Status	12. Was Decedent Armed Forces	?	13. V	Vas Decedent of Yes, specify Cut	Hispanic Original Mexican	gln? (Sp , Puerto	ecify Yes or No Rican, etc.)		ace - Ameri lack, White	
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21215-0020 d within 72 hours ef giene. rr than "natural", or , the Moulce Exam	8	15. Decedent's E	Year or Dates:		B Deced	ent's Usuel Occu	nation			16b. Kind of		
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2000		19a. Informant's Name/Relationship				g Address (Stree						
C = 2 L		JOHN H. DUFF/HUSI	BAND			RACE STE	REET,	CAMB	- т			
		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 I	Removal from State	ceme	fery, crem	lition (Name of netory or other ple		1	Date	20c. Location		
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Baltimo permit. Page Department of Important: If I any injury or		21. Signature of Funeral Service Cice	LM.		22. Z	Name and Addr ELLER FU	ess of Facilit INERAL	HOM	E, P. C	BOX	207,	
		Boner &	x gar	_	E.	AST NEW	MARKE'	Т, М	D 21631			
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Physician /Medical	-	Immediate Cause (Final	Manager 1 and 1		_					_	f	0.1001 0.10 0.0011
Examiner		disease or condition resulting in death)	Metas	2 Frote	24	Acronor	s Ce	//	Lung	Cena		140
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So, se son crisi-		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Chain	e als	2	ue Fiera	8.5	Sand	ency	Oise	4	10 00
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x 8 5 8	Completed								10	Yes 2 DN6		☐Yes 2☐No
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SION tending eeth. or: After the fune	catic	2 Accident Investigation]Yes 2 1	No				
DIVISION OF VITAL t or Attending Physician: The effer death. Director: Affer this certificate in by the funeral director, pa	Certification:	3 Suicide 6 Could not to determined	286. Place of th	ijury - At home, tc. (Specify)	farm, stre	et, factory, office			28f. Location (City or To		nber or Rui	rel Route Number,
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F # F 8		R	2 \		-			211	7	5/	1.2/	61
		30. Neme and address of person who	completed cause of	deeth (Item 23a	(Type F	Print)	320	14	<u></u>	3/	3/	
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° St	ate	31. Date filed (Month, Day, Yeer) MAR 2 0	32. Regist	rar's Signature	R	J. N		- 10	33 00 1	2001.00	7	1. C 11,00
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dey Arlene 15 J. Demby March 19, 1998 /Medicai 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mallard Bay Center Cambridge Dorchester If Under 1 Yeer | if Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) **Funeral** 1□M % F 213-80-0131 73 Yrs. Director August 30,1924-Maryland Usual Residenca of Decedant the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits regat be notified at 1 Yes 2 □ No Maryland Dorchester Director Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? death with 706 Douglas Street 21613 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: r than "natural", or items the Medical Examiner re-14. Rece - American Indien, Bleck, Whita, etc. Black Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 21 No Specify: þ Specify 3 Nidowed 4 Divorced Completed 16e. Dacedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Hygiene. Dorchester Elementery/Secondary (0-12) Collega (1-4or 5+) 1 - 12None House Keeper General Hospital traumatic event. Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be fament of Health and Mental Int. If item 27 Is marked of Calvin Aldridge Jackson Elsie 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) Debra Demby 706 Douglas Street-Cambridge, Maryland-21613 other t or other 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete March Burial 2 Cremetion 3 Removel from Steta permit. Page Department of Important: If any injury or once. East New Market Mt.Zion UM Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 23,1998 Maryland 21. Sloneture of Funeral Service Licensee 22. Name end Addrass of Facility Boardley Funeral Home 21613 Doord 812 Hubbard Street Cambridge, Maryland Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Ь Approximeta Intervel Between Onsat and Death **Physician** /Medicai Immedieta Ceuse (Finel diseese or condition resulting In death) Examiner Examiner The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Entar Underlying Cause (Olseese or Injury that initiated events resulting in deeth) Lest end Due to (or es e consequença of): P.O. Box 68760, physician Physician/Medical Dua to (or as a consequence of) Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? S Probably 4 Unknown PVD 1 Yes 2 No of Vital Records, þ 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24a. Was en eutopsy performed? 1 Yas ZONO 1 Yes PSNo certificate or Attanding Physician: Be 25. Wes case rafarred to medical axaminer? 26. Placa of Deeth (Check only ona) 1 Yas 20 No Hospitel: 1 ☐ Inpalian 2 ☐ ER/Outpelien 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 2 this 27. Mannar of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After Division 5 Pending s efter death. 1 Yes 2 No investigation 2 Accident in by the 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - Al home, farm, street, factory, offica building, atc. (Specify) Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is 29a. Certifiar Medical 🔀 Cartifying Phyefcfan: To tha bast of my knowledga, daath occurred at the tima, deta end place, and due to the ceuse(s) end mannar as stated. 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daeth occurred et the time, dete end pleca, end dua to the causa(s) and menner steted. 29b. Signeture end little of confiller 29c. License number 29d. Dete signad (Month, Dey, Yeer) 30. Neme end addrass of person who completed causa of death (Itam 23e) (Type, Print) Canchidge mo 21613. 105 Aurora hmed 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State 3/20/98MAR 2 0 1998 Registrar



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Physician /Medical		1. Decedent's Name (First, Middle, I SYLVIA A. DUN Ie. Facility Neme (If not institution, g	LEY	m har)	14			b. City, Tov			h 1	Day 6, 199		3:45
Examiner	ľ	DOCTORS HOSPITA		m <i>oerj</i>			4			ation of De	9(1)	4c. County		
Funeral Director		5. Social Security Number 6.	Sex 1□M 2∏XF	7. Age (In yrs	s. last birthday) Yrs.	If Unde Months	r 1 Year Days	LANH If Under 2 Hours	24 Hrs. Min.	8. Date of I (Month,	Birth Day, Ye	PRINC 1912	9. Birth	olace (State or F ntry)
		119-12-2012 Usual Residence of Decedent								,	-,		MAR	YLAND
ms 23s or 28s-f show creat be notified at		MARYLAND PRIN	CE GEORG	TPC	City, Town or Loc PPER MAI		RO						1	10d. Inside City I
or 28a-f si be nourled Director	1	10e. Street and Number				10f. Zij	Code				10g.	. Citizen of V	Vhat Cou	ntry?
al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director		10901 MT. LUBFT	12. Was Dec	edent Ever in lorces?	U,S. 13. V		0772 dent of Hi cify Cuba	ispanic Orig n, Mexican,	in? (Spec	cify Yes or !		14. Raci		S AMERI can Indien, etc.
		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	if Yes, Gir Year or D	ve	1	☐ Yes	2X) No	Specify:				Specify	BLA	CK
Hygiene "natural", or ite the transfer than "natural", or ite mt. Ita Medical Examine Completed by Fui	-	15. Decedent's (Specify only highest g		1-4or 5+)	life. D	kind of wo OO NOT u	ork done d se retired	lurina most	of workin	g		b. Kind of Bu	ısiness/în	dustry
The State		7. Father's Name (First, Middle, Le			CLERI	V TII	TST	18. Mother	r'a Name	(First, Midd	-	OVT . Ide <i>n Sum</i> am	e)	
d Mental H		ORIE TYLER			401 14-111-		(2)	L	OUIS	E MAC	ER	7,202.70		
permit. Pages 1 and 2 should be filed within 72 in the page and the page of th		19a. Informant's Name/Reletionship ANTTA L. SHREST 20a. Method of Disposition 1 Built Q Cremation 3	THA (DA		10001	MT.	LUBE	NTIA			R M	ARLBOF c. Location -	80, M	D. 2077
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hysiclan /Medical		Enter the disease, or connects, or heart failure. List oni	y one cause on e	Acri inte.		er the mod	de of dyin	g, such as o	cardiac or	respiratory	arrest,			Approximate Interval Betwee Onset and Dee
xaminer	1	disease or condition resulting in death)	a		lopu (or es e consequence)	uenca of):	mo	4	an			-		10de
physicien and the buriel-transit dicai Examiner	000	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	Due to (of as a consequence	uence of):	Va	cul	m	de	u	se		3 with
die the	1	hat initiated events resulting in death) Last			or as e consequ		_							3 das
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d by the letached		art II. Other significant conditions	contributing to de	eath but not re	sulting in the un	derlying	cause give	en in Part I.						the cause of c
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deeth. tor: After / the fune ication		1 Netural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	on be on Slave	th, Day Year)	28b. Time of Injury	М		ret (? /es 2 □ N	lo			Injury occurr		al Route Number
24 hours efter Funeral Direction by etely filled in by cdical Certif	2	4 Homicide determine	buildie	ng, etc. (Spec	ify)			e dete and		City or T	own, S	State)		
n 24 hours he Funeral pletely filled edical Co		(Check only 2 Medicat Exs	iminer: 🎾n the ba	asis of exeminated	ation end/or inv	estigetion	, in my op	olnion, death	h occurre	d at the time	e, dete	end piece,	and due to	the cause(s)
Me		9b. Signature end title of cartifier	16		w	29	c. License	number 3199	17		29d.	Date signer	(Month.	Pay, Year)
	3	0. Neme and eddress of person who	completed aus	o of south (to	m 23a) (Type, F	Print)	4 4	ne 1	mbi	n-w	oy 1	#202 What	Til	well "
State	3	1. Date filed (Month, Day, Year)	32. R	egistrar's Sign				•						•

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \begin{align*} \text{ Bold of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \begin{al Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Doswel march 98 18 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Southern Ma tospi ta 6. Sex If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Deys Hours 1 M 20 F Yrs 578-28-5681 74 Oct. 18, 1923 Arrington, VA Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 TYPes 2 □ No Maryland Forestville Prince George's 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7420 Marlboro Pike 20747 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status Never Married 2☐ Married 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify Black 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Private Elementary/Secondary (0-12) College (1-4or 5+) Manager -Bakery Giant Food, Inc. 12 17. Fether's Neme (First, Middle, Last) John Clarkson Doswell Elsie Allen 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 0748 19e. Informent's Neme/Reletionship (Type, Print) 2600 Keating Street, #311, Temple Hills, MD Susie Eula Jackson 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Harmony Memorial Park 3/23/98 Landover, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, It is. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or as e consequence of) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Sepcis 1 Yes 2 No 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 1 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

Physician /Medicai Examiner

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f ahow must be notified at

ծ Herns 23a

"naturel", or

permit. Pages 1 end 2 should be filed within 7; Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Head ones.

traumatic event, the Medical Examiner

Director

Funeral

by

Completed

Be

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

sician and burial-transit ettending physician for usa as tha buria igned by t page 2 88 2 ŝ Atter s after dead at Director: Aft

The law requires that the death certificete be executed

Box 68760.

P.O.

Records.

Division of Vital

Attending

0 Hospital

8

Physician/Medical Examiner P Completed Certification:

within 24 hours a To the Funeral C completely filled Medical

1 Yes 2 10

27. Menner of Deeth

1 Naturel

2 Accident 3 Sulcide

4 Homicide

29b. Signature and file of d

D. Haye

30. Name and address of person

31. Dete filled (Month, Dey, Year)

29a, Certifier (Check only

State Registrar

5 Pending Investigation

6 Could not be



who completed cause of deeth (Item 23e) (Type, Print

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work?

1/1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end menner steted.

29c. License number

1)26352

1 ☐ Yes 2 ☐ No

28e. Dete of Injury (Month, Dey Year)

was a superior

98-1421-033 ihm DAVID DICKERSON **Physician** 10/1 /Medical

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day MARCH 14, 1998 05:25 AM DAVID ERIC DICKERSON 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) PRINCE GEORGES

9. Birtholace (Stete or Foreign

WASHINGTON DC

10d. fnslde City Limits

Approximete Interval Between Onset and Deeth

24b. Were autopsy findings avellable prior to completion of cause of death?

MARCH 14, 1998

Yes 2□No

Funeral Director

Examiner

with the Manylend must be notified at death

Directo Funeral r than "natural", or items the Medical Examiner m

permit. Peges 1 and 2 should be filed within 72 hours after teppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examina Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the bunal-tran certificate be 98 USB 0 signed by the a hes page 2 certificate funeral director, After this

6 Hospital npletely To the I within 2 To the I complet

Attending Physician: after death. n 24 hours after dei ne Funerel Directo bletely filled in by th

Box 68760. 0 Records, by Completed Division of Vital Certification: To Medical

Completed Be Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical that initiated events resulting in death) Last

þ 3 ☐ Widowed 4 ☐ Divorced Elementery/Secondary (0-12) LEE DICKERSON 20e. Method of Disposition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated exerts. 25. Was case referred to medical examiner? Yes 2□ No 27. Manner of Death 1 Naturel

BRANDYWINE
If Under 24 Hrs.
Hours Min.
JULY 299, 19953 6300 ACCOKEEK ROAD If Under 1 Yeer 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) 1**X** M 2□ F Months Days 578-74-8912 44 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location UPPER MARLBORO PRINCE GEORGES MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 IISA 13720 CAPTAIN MARBURY LN 12. Was Decedent Ever in U,S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 ☐ Never Married 21X Married Specify: BLACK 1 ☐ Yes ZONo Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) GOVERNMENT FIRE INSPECTOR 18 Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) FLORENCE WARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13720 CAPTAIN MARBURY LN. UPPER MARLBORO MD 20772 MARY DICKERSON / WIFE 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3-19-98 BRENTWOOD MD FORT LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOMES of Funeral Service Lin 5538 MARLBORO PIKE FORESTVILLE MD 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. nsequence of): Due to (or as a consequence of) Due to (or as a consequenca of): 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2□ No 1 No Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA SCENE 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of anto injury 5 Pending 3.14.98 1 Yes ≥QNo 281. Location (Street and Number of Rurel Route Number, City or Town, State) 2 Accident investigation 0000 6 Could not be determined 3 Suicide 28e. Placa of fnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homlcide Street 6300 Arkokek ld

29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

OCME

30. Nini completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

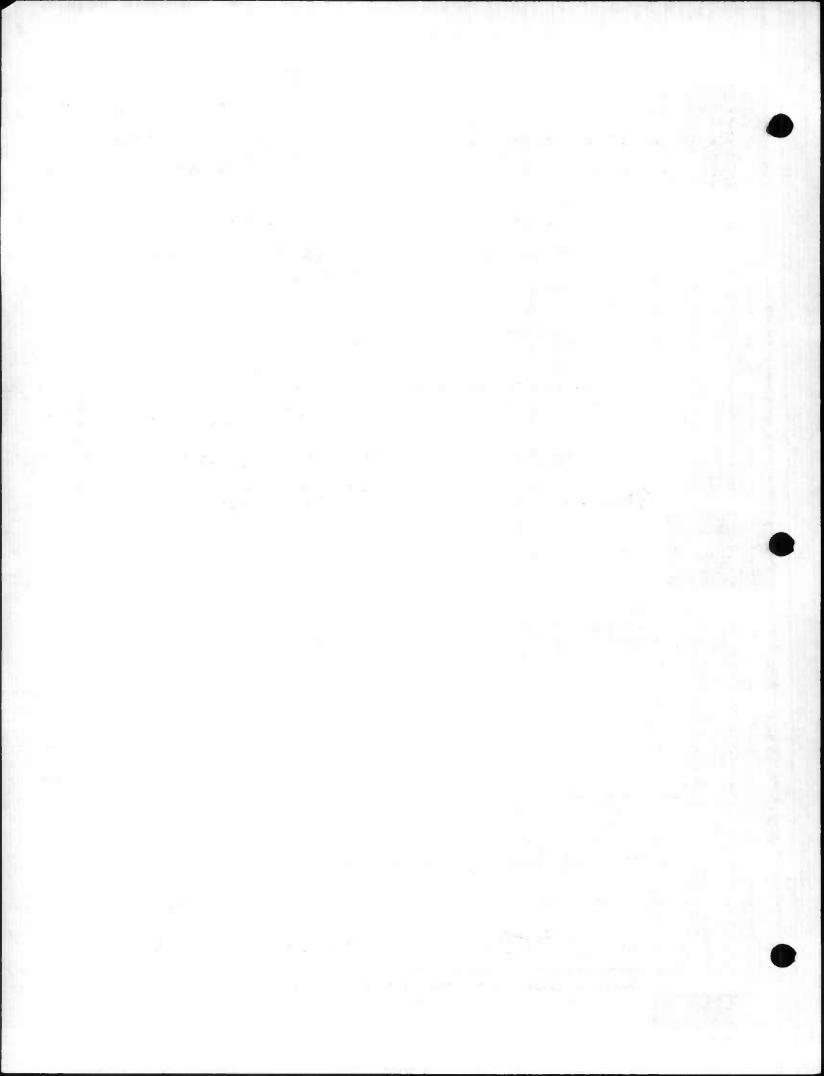
31. Date filed (Month, Day, Year) State Registrar

Registrar's Signature

AND TO 18 1990 William Boles

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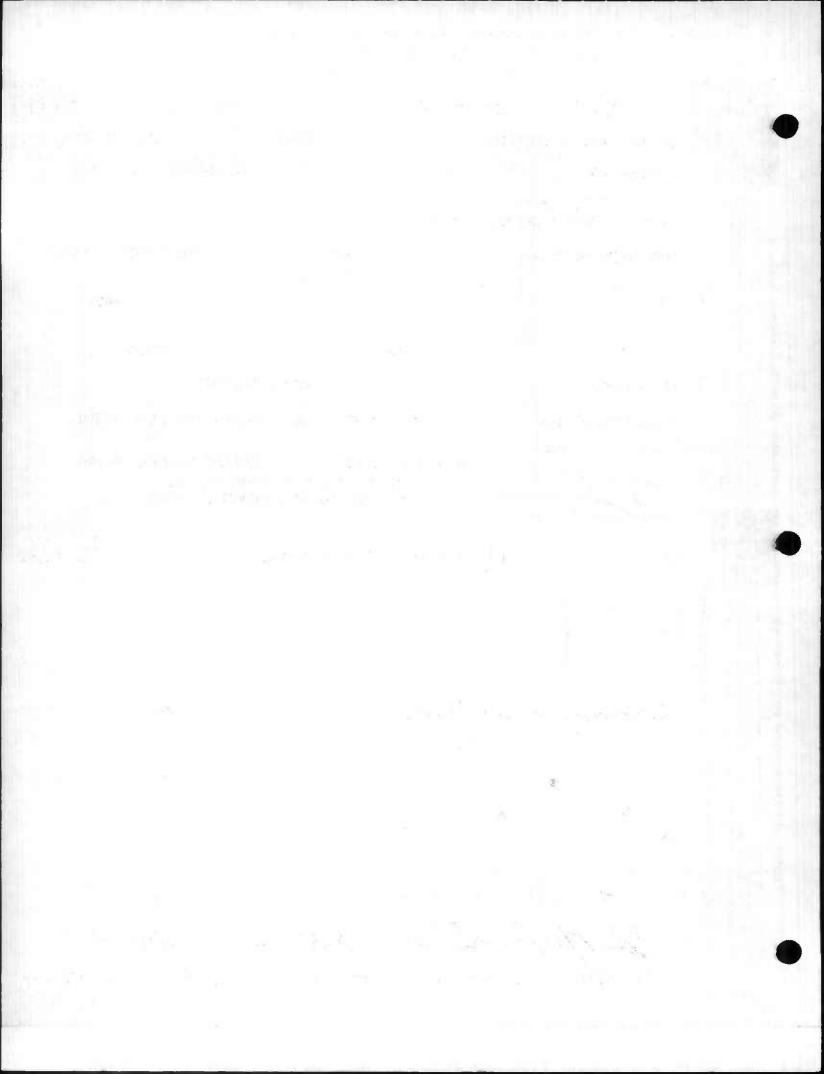
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	Physici		Decedent's Neme (First, Middle,	Margare	t C.	Dew	,		2. Dete of De Month 03	Day 10	Year 98	3. Time of Death 9:40AM
	/Medid Examir		4a. Facility Neme (If not institution, g	ive street and number)			4b. City, Town, or		h 4c. County	of Death	J. 40AII
_			CAROLINE NURSII 5. Social Security Number 6			ant histhete	v) If Under 1 Year	DENTON if Under 24 Hrs	a Data of Di		LINE	
	Funeral Director		213-22-7091 Usuel Residence of Decedent	10 M 20 F	ge (In yrs. li 8	6 Yrs.	Months Deys	Hours Min.		y./194	V11	lace (Stete or Foreign try) ginia
	wor.		10e. Stete 10b. County		10c. City	, Town or	Location				10	0d. Inside City Limits
	Mar st	ctor	MD Caro	line			Fe	ederals	burg			1 ☐ Yes 2√2 No
	h with th	Funeral Director	10e. Street end Number 26431 Chipma	ans Lane			10f. Zip Code	21632		10g. Citizen of V United		
21215-0020	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show and, the Medical Examples must be muffied at	by	11. Meritel Stetus 1 Never Merried 2 Merried 3 Midowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 24 If Yes, Give Year or Detes:	Ever in U.S No	S. 13	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispenic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	14. Race Bled Specify	e - America k, White, c Wh	
5-0	72 ho 'netur	eted	15. Decedent's (Specify only highest g	Education trade completed)		16a. Dec	edent's Usuel Occup ve kind of work done . DO NOT use retired	eation during most of wo	rking	16b. Kind of Bu	isiness/ind	lustry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		. DO NOT use retired cretary	d)		Cannin	g Ho	uses
pu	2 should be filed withing and Mentel Hygiene. Is marked other then summitic svant, the Mentel Standard	Be Co	17. Father's Neme (First, Middle, La	st)				18. Mother's Ne	me (First, Middle	, Melden Sumem	e)	
Maryland	Mente arked	To		m Richard	Hin				t E. Ei			
Mai	s 1 and 2 should I Heelth and Mer tam 27 is marke other traumatic		19e. Informent's Neme/Reletionship Stewart J. Dev				iling Address (Street Liberty					
Baltimore,	permit. Peges 1 and 2 Department of Heelth Important: If Itam 27 I sny injury or other tri once.		20e. Method of Disposition 1 Burlel 2 Cremation 3 4 Donetion 5 Other (Special Control of Control		Ce	metery, cr	position (Name of remetory or other please Cen	netery	Dete 3/12/98	20c. Location - Federa		
Balti	permit. Peges Department of Important: If its sny injury or o		21. Signeture of Funerel Service Llo	Esker		F	22. Neme end Addre	ss of Fecility -Hawkin:	s-Eskov	v Funer	al H	Iome
			23a. Part1. Enter the disease, or co shock, or heart feilure. List on	mplications thet cause y one ceuse on eech l	d the deeth							Approximete Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a m	10C	ard	ial in	Parct:	01)			Onset end Deeth minutes
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	and transi	Examiner	Sequentially list conditions,	b	Due to (or		equence of):	Oct 26	476		O	ears
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x 687	deeth certificate be executed e attending physician and ed for use as the bunal-transit	Medical	resulting in deeth) Lest	l d	Due to (or	es e cons	equenca of):				1	
Вох	eeth certifice attending pl	clan	David Oshar davida and data									
P.0.	by the destached	Physician/M	Pert II. Other significant conditions	_	,	_		en in Pen I.		Yes 2⊠ No		the cause of death?
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of Vital Records,	aw requ	Completed								en eutopsy ormed?	ave	ere autopsy findings eliable prior to mpletion of cause death?
a B	E sag								10	Yes 2 No	10	Yes 2 No
Zi.	A	o Be	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospitel:	ont 201	ED/Outpot	ent 3 DOA Oth	on.	eth (Check only		/C=/h	d
ion of	ding Phy th. : After this e funeral d	-	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investiget	28e. Dete of Inju (Month, De	Jry	28b. Time Injury	of 28c. injur			dence 6 Oth-		7
Division	To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	d 28e. Piece of in	jury - At hor ic. (Specify,		street, fectory, office	10	28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	I Route Number,
	Hospit 24 hour Funers interly fille	edical (29e. Certifier 12 Certifying F (Check only one)	Thysician: To the best minar: On the basis of and manner st	f examineti	riedge, des on end/or	eth occurred at the tir investigation, in my o	ne, dete end plece plnion, deeth occu	a, and due to the urred at the time,	cause(s) end me date and place,	nner as st and dua to	ated. the cause(s)
	Within To the comp	×	29b. Signeture and title of certifier	JU:			29c. Licens	e number		29d. Dete signed		Day, Year)
				CALT			1047	1234		3/10/	98	
			30. Name and eddress of person wh Wafik Zaki,				e, Print) reet, Dent	on, MD	21629			
	Sta Registra	-	31. Dete flied (Month, Dey, Year)		rer's Signet	ure	Donlor	_				



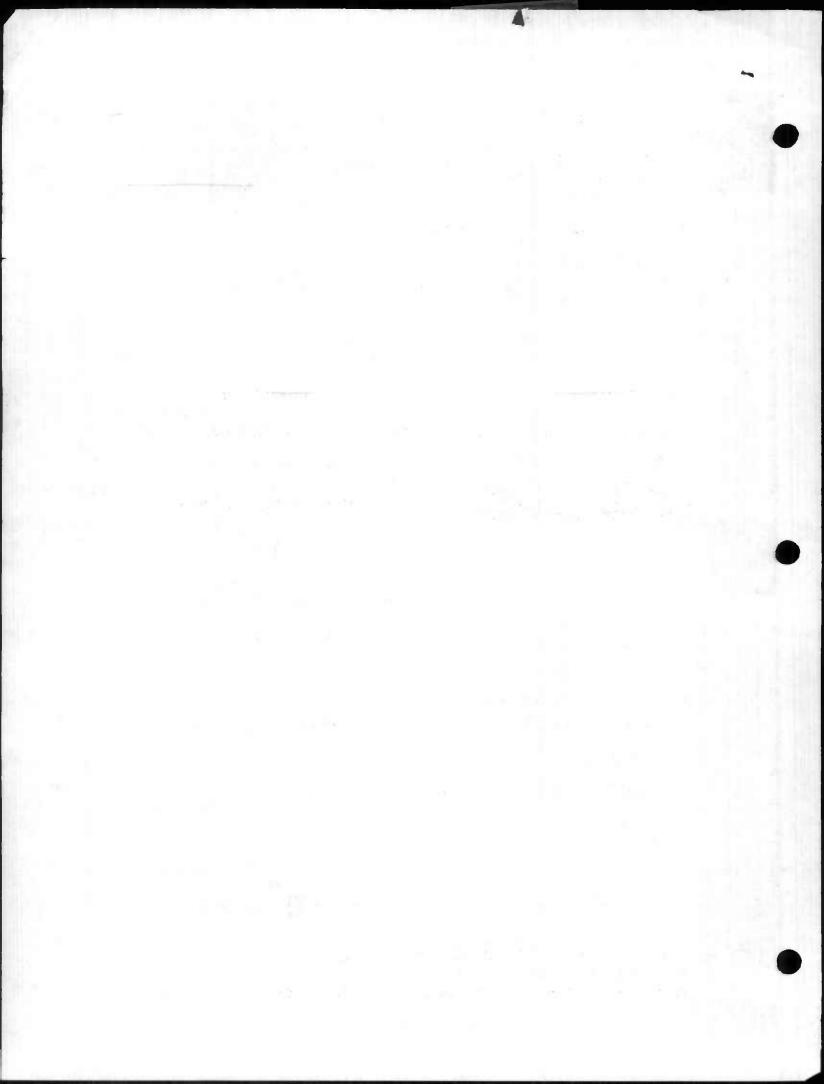
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State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	R	eg. No. 98	10027
Physici /Medic		1. Decedent's Name (First, Middle, Last) Epstein	J		2. Date of Deat Month		Year 3. Time of Death
Examin		4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL		4b. City, Town, or L	ocation of Death	4c. County o	f Death E GEORGE
Funeral Director		5. Social Security Number 6. Sex 1 M 2 D 7. Aga (In yrs. las	st birthday) If Under 1 Yaar Months Days	If Undar 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foraign NEW YORK
wo m		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location				10d. Inside City Limits
r 28e-f ehow	ctor	MARYLAND PRINCE GEORGE LAURE	EL				1 ☐ Yes 2 HNo
ath with the 23a or 28	Funeral Director	10e. Street and Number 9000 BRIARCROFT LANE	10f. Zip Code 20708			Og. Citizan of W	hat Country? IES OF AMERICA
d 21215-0020 filed within 72 hours after death with the Marylend thygiene. ther than "naturel", or items 23s or 28s-f show int, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yas, Giva Year or Dates:	13. Was Decedent of H If Yas, specify Cub 1 □ Yes 2₺ No		pecify Yes or No- Picen, etc.)		- American Indian, , White, etc.
21215-0020 d within 72 hours af giere. r than "naturel", or the Medical Exemple.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire HOMEMAKER	during most of work	king	16b. Kind of Bus	
and 212 be filed withintal Hygiene. Ind other than event, the M	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, N)
Maryland ad 2 should be file th and Mental Hy 27 is marked other traumatic event	٩	NATHAN REISS 19a. Informant's Name/Relationship (Type, Print)	10h Malling Address (Ctros)		UNKNOWN"		No. 4. Tin Confes
			19b. Malling Address (Street 8704 GRAYSTON)				
5 - 3 E 4		4 Densities 5 Dotters (Constitution State	ce of Disposition (Name of netery, crematory or other pla	l l	Date 3/16/1998 1		City or Town, State
Baltimol permit. Pages Department of Important: If it any injury or once.		21. Signature of Pilneral Septice Licensee	22 Name and Address EDWARD SAGEI	FUNERAL D	IRECITON,	INC.	
		23a Part 1. Ectar the disease, or complications that ceused the death.					Approximate Interval Between
Physician /Medical Examiner			dial Infar	ction			72 hours
Box 68760, death certificate be executed e ettending physician end ad for use as the bunial-transit	Physician/Medical Examiner	if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.	is a consequence of):				
Box eath cert	an/M	d					
the death by the ette	ysici	Part II. Other significant conditions contributing to death but not resulti	ing In the underlying ceuse gi	van in Part I.	23b. Did to	bacco use cont	ribute to the cause of death?
	þ	Coronary artery Dis	raje_		1 □ Ye	No No	3 Probably 4 Unknown
SCOPC ow requir	Completed				24a. Was a perform		24b. Were autopsy findings available prior to completion of ceuse of death?
		Or Mississian Country			1 □ Ye		1 ☐ Yes 2 ☐ No
of Vita Physicien: this certific	To Be	25. Was cese referred to medicel examiner? 1 Yes 2 No Hospital: 1 npattent 2 E	R/Outpatient 3□ DOA Oth	or:	th <i>(Check only on</i> ome 5 ☐ Reside		(Spacify)
Division of Vital or Attending Physicien: The after death. Director: After this certificat in by the funeral director, partitions in the funeral director in the		· panpanon 2 c	8b. Time of 28c. Injury		28d. Describe ho		
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		28f. Location (St. City or Town		r or Rural Route Number,
Hospi 24 hours Funer etely fil	edicai	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time n and/or investigation, in my c	me, date and place, opinion, death occur	and due to the carred at the time, da	use(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
(Me	290. Signature and title of certifier layers in	29c. Licans	sa number 1543 C)	9d. Data signed 3/14/	(Month, Day, Year)
Q		30. Name and address of person who completed cause of death (Item 2:	3a) (Type, Print) 4333 25 UNE	1-Powe	e Rel 1	+ 307	Lawel 40 2028
Sta	te	31. Date filed (Month, Day, Year) 32, Registrar's Signatur	March 92				



		1. Decedent's Neme (First, Middla, Las	t) ,	Certificate o	2. Deta o	Reg. No.	3. Time of Death
Physic /Medi	cal	MAR GARE 4e. Fecility Nema (If not institution, give	T HOPE	ECKEN	ROTH MAK 4b. City, Town, or Location of D	CH 15, 199	8 9:27A
Exami	ier	Washington Advention S. Social Sacurity Number 6. Se	tist Hospital		Takoma Park	Montgome	ry
Funeral Director			DM 2☐F 82	rs. lest birthday) If Undar 1 Yas Yrs. Months Dey	Hours Min.	er 29,1915 N	irthplace (State or Fore Country) Iew Jersey
-f show	tor	10a. State 10b. County MD Howard		City, Town or Location			10d. tnside City Lim
3a or 28a	Il Director	10e. Street and Number 12946 Byefield	Dr.	10f. Zip Code 2077		10g. Citizen of Whet C	Country?
permitter agos a rando de med when the mous area death with the maryland important. Tages that had Mental Hygiene. Important: if Item 27 is marked other than "natural", or from 23a or 28e-f show any injury or other traumatic event, it a Medical Examinal must be notified at once.	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 也Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give # Yeer or Dates:		f Hispenic Origin? (Specify Yes o uben, Mexican, Puerto Rican, etc. o Specify:	or No- 14. Race - An Bleck, Wh	
n natur	Completed	15. Decedent's Ed (Spacify only highest green	de completed)	16e. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	upation e during most of working red)	16b. Kind of Busines	s/Industry
giena	Com	12 Elementary/Secondery (0-12)	College (1-4or 5+)	Teacher		Education	
d off	Be	17. Fether's Neme (First, Middle, Last)	T =====		18. Mother's Name (First, Min	ddle, Meiden Sumema)	
Men Meric	10	Clarence Lowery	**		Manual Henry		
th end 7 is n		19e. Informant's Name/Reletionship (7 Ruth Ann Parish (1			et and Number or Rural Route No od Dr. Highland	-	, Zip Code)
Heal Sm 2		20a. Method of Disposition		. Place of Disposition (Neme of	Dete	20c. Location - City of	or Town, Stete
rtment of rtant: If I		1 Surlel 2 Cremetion 3 4 Donetion 5 Other (Specify) Ge		n Cemetery 3-18		
Depa Impo		21. Signature of Foneral Service Licens	2///		lress of Fecility Hines-Ri		New Hamps
	-4	23e Pert1 Enter the disease or como	lications the caused the de		er Spring, MD 2		Approximete
hysician /Medical		23e. Pert1. Enter the diseasa, or comp shock, or heert feilure. List only of Immediate Cause (Finel disasse or condition		PTIC SHOO		.,	Intervel Between Onset and Deeth
xaminer		resulting In deeth)	Due to	o (or es e consequance of):			
sit	nine		b. RESI	PIRATORY F	AILURE		
sician end burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	PIRATORY F (or es e consequence of): ORATION			
siciar e buri	70	cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events	· PERF	ORATION :	RECTUM		
attanding physic	pa	resulting in death) Lest	Dua to	(or as a consequence of):			
andin	an/Ne		d				İ
the att	sicia	Pert II. Other significant conditione co	ntributing to deeth but not re	esulting in the underlying cause	given In Part I. 23b.	Did tobacco usa contribu	te to the cause of de
gned by be datac	by Physician/Medic	Renal Fa	ilure;	Hypertensive f	Heart Disease	1 Yes 2 No 3	Probably 4 Onk
has been s	Completed	Degenerati	ue joint	Disease	24e. \	Wes en eutopsy 24b performed?	. Were eutopsy findin eveileble prior to completion of causa of death?
	Be Com	Gartno in tes	tinal Ble	eeding with Se	26. Place of Deeth (Check o	1 Yes 2 No	1 ☐ Yes 2 ☐ To
ls cert	ToE	axaminar?	Hospitel: 1 Inpatient 2	□ ER/Outpetient 3□ DOA	Other: 4 Nursing Homa 5 1		ecify)
rthis arai d		27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)		jury et 28d. Descrizork?	ribe how Injury occurred	
f Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spec	t home, ferm, street, factory, offic		on (Streat end Number or i r Town, Steta)	Rural Route Number,
after death. Director: After this certific in by the funeral director.		29a. Certifier 1 Certifying Phy	sicten: To the best of my ki	nowledge, death occurred et the netion end/or Investigetion, In my	time, dete end plece, end due to	the cause(s) and manner ime, dete end piece, and di	as stated. ue to the cause(s)
24 hours after death. Funeral Director: Afte	lical Co	(Check only 2 Medical Exam	and manner stated				
within 24 hours after To the Funeral Dir. completely filled in	Medical Co	(Check only 2 Medical Examinate) 29b. Signature and title of cadifler.	end manner stated.	29c. Lica	nsa number 5 4 9	29d. Dete signed (Mo	- 4 -
within 24 hours aftar death. To the Funeral Director: Afte completely filled in by the fune	Medical Co	(Check only 2 Medical Exam	end manner stated.	M.D. D	22549	29d. Dete signed (Moi	- 4 -



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Daia of Death 3. Time of Death Month Dey 2:00 a.m. Jane Ellerby 8, 1998 March 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 15 Ashcroft Court Arnold Anne Arundel | Months | Days | Hours | Min. | 8. Dete of Birth (Month, Dey, Year) | Nov 3, 1930 Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) Monihs 1□M 2 F 67 Yrs. Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Arnold 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizan of What Country? 15 Ashcroft Court 21012 USA 12. Wes Decedani Evar in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Ricen, atc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Fethar's Nema (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) William G. Hockensmith Josie Furrow 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William T. Ellerby/husband 15 Ashcroft Court, Arnold, MD 20b. Plece of Disposition (Meme of cematary, cremetory or other piece)
Moreland Park Cemetery Dete 20c. Location - City or Town, Stete 1 Burlei 2 Cremation 3 Removal from State Mar 10 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 1998 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Fuperal Service Leb 495 Gov. Ritchie Hwy., Seven 495 Gov. Ritchie Hwy., Severna Park, MD r the diseese, or aart failure. List Proumonia IWK dementia. INTRUCT Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hhknown (bed-band 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

/Medical Examiner Box 68760, physician a 8 The law requires that the death certificate ed by the a Division of Vital Records, P.O. signed by certificate has or Attending Physician: after death. Director: After this certifica To the Hospital of within 24 hours a To the Funeral D completely filled

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

2 should be filled within 72 hours after o and Mental Hygiens. is marked other than "natural", or its

permit. Pages 1 and 2 an Department of Health and Important: If here 27 is m any injury or other traun otice.

Physician

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funeral

p

Completed

Be

2

the Maryla

Betty

5. Sociel Security Number

213-28-8466

10a. State

MD

11. Maritel Stetus

10e. Street and Number

20a. Method of Disposition

Usual Residence of Decedent

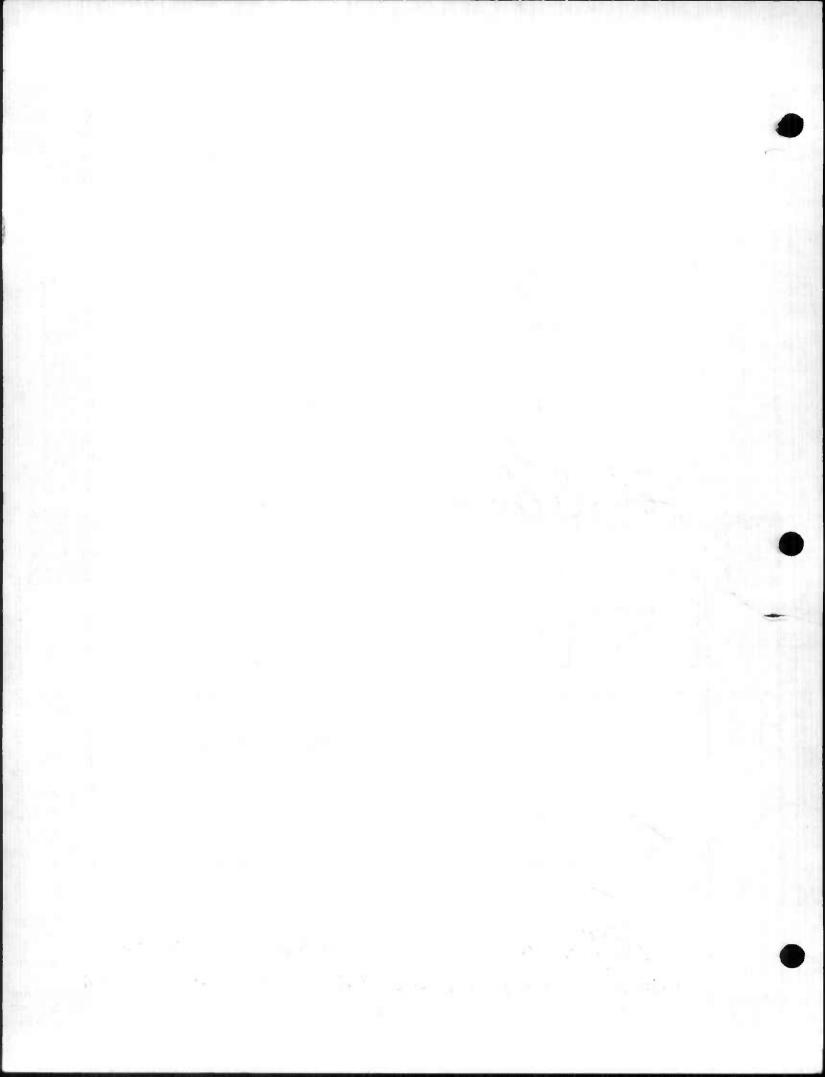
Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ blind Completed my pertension 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 212 No Certification: To 27. Manney of Death 1 Senatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide 29a. Certifier 🗺 Certifying Physician: To tha bast of my knowledge, deeth occurred et the time, dete end piece, end due to tha cause(s) and menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the lime, date end place, and due to the cause(s) end menner stated. 29c. Licensa number 29d. Date signed (Month, Dey, Year)

D44161

State Registrar

200 Triman Paitway, Annopolis, mo 21401 Czapp, wo 32. Registrer's Signeture MAR 13 1998

30. Name and address of person who completed ceusa of daath (Itam 23a) (Type, Print)



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

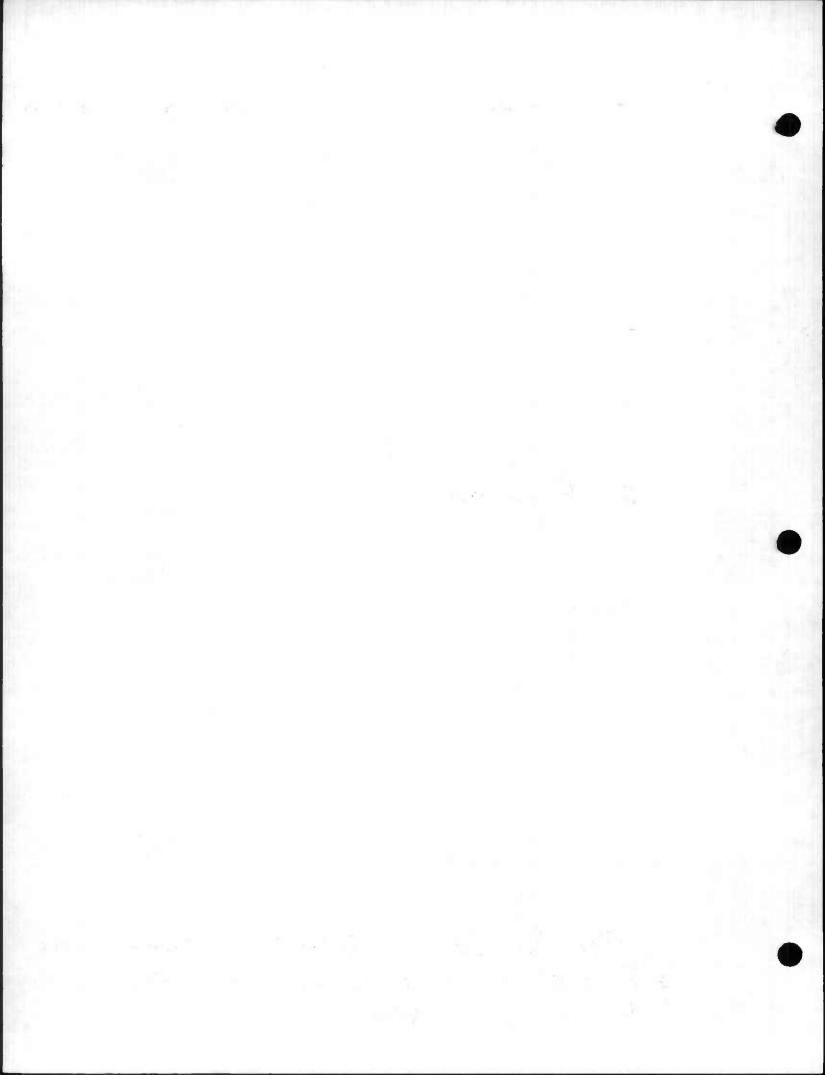
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3 Time of Death **Physician** Month 35 AM CARL ECKERT MARCH /Medical 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park Anne Arundel 202 Pine Avenue 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Oct 30, 19 Birthpiace (Stata or Foraign Country) **Funeral** Days 1⊠M 2□ F Country Illinois 334-05-9504 Yrs. 82 Director Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Mexical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yas 2 ☒ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 202 Pine Avenue Items 23a 21146 USA Peges 1 end 2 should be filed within 72 hours efter deeth nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedant Evar In U,S Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 □ Never Marriad 2 M Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Spacify: þ Specify: White 3 Widowed 4 Divorced WWIT Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) Accounting Certified Public Accountant 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Leo Ross Eckert Unknown 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Heelth a Important: If Item 27 is any injury or other train 202 Pine Avenue, Severna Park, MD Dorothy H. Eckert/wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata March 9 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1998 21. Signature of Funeral Service Lipense 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD calions that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disease or condition readiting in death) /Medical LUNG CANCER CELL Due to (or as a consequence of): Examiner Hospital or Attending Physician: The lew requires that the death certificate be assicited 24 hours after deeth. Funeral Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician s the burisk Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? certificate has b 1 Yas 1 Yas 2 No director. Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Naturai 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homlcide To the Hospital of within 24 hours at To the Funeral Discompletely filled it Medical 29a. Certifiar 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licensa number
D 163 54

MARCH 29b. Signatura and title of certifian 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

EW COLE GOO BESTGATE SUITE 300 ANNAP, MD 2140) 32. Registrar's Signatura State Sulia Davidson-Randalle Registrar

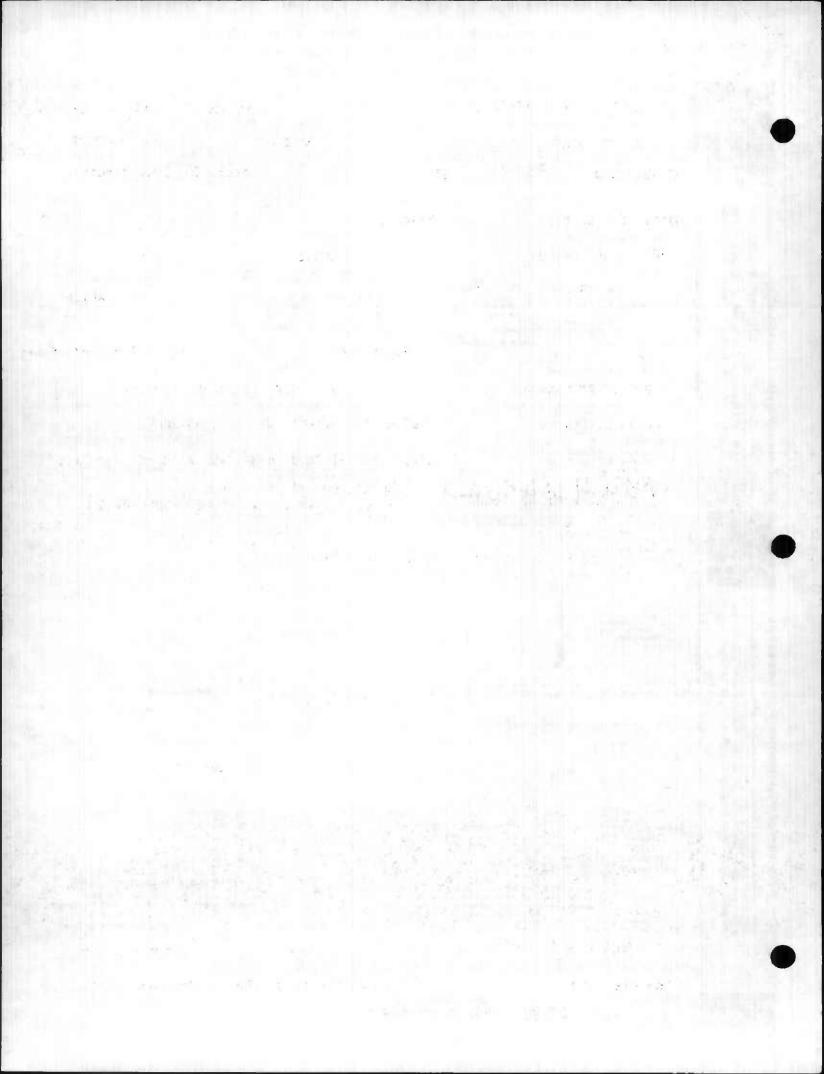


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LTON S. E			State of Ma	aryiano		rtificate			nemai My	Reg. No.	8 10	0031
		I. Decedent's Name (First, Middle, Las	t)						2. Date of Do Month	eeth Dey	Year	3. Time of Deeth
Physician - /Medical		MILTON SAMUE	ECKARD,	SR.						13, 1998		2240PM
Examiner		le Facility Neme (If not institution, give	street end number)				4b. City,	Town, or L	ocation of Deal	h 4c. Count	y of Deeth	
	_	406 GARNER AVENUE		- //	-4 6 246 -6 -1	If Under 1 Y		DORF er 24 Hrs.	8. Date of Bi		LES COU	
Funeral Director	!	5. Sociel Security Number 6. Sociel 577 – 54 – 6550 July 1. Sociel Security Number 6. Sociel 577 – 54 – 6550	X M 2□F	je (In yrs. le 57	Yrs.		eys Hours		Sept.	20, 1940	Virgi	e (State or Foreign) nia
yland W	-	10e. Stete 10b. County		10c. City,	Town or Lo	ocation					10d	. Inside City Limits
72 hours effer death with the Maryland natural; or items 23a or 28a-f show dost Examiner must be notified at each by Funeral Director	5 1	Maryland Charle	5	V	valdor	rf						1 ☐ Yes 2 ☐ No
offer death with the Ma writems 23s or 28s-fs place must be norfilled Funeral Director	1	10e. Street and Number				10f. Zip Co				10g. Citizen of	Whet Country	7
w the		406 Garner Aven					20602			USA		
tems tems	1	11. Meritel Stetus	12. Wes Decedent Armed Forces?		5. 13.	Wes Decedent If Yes, specify	of Hispenic (Cuben, Mexic	Origin? (Sp an, Puerto	ecity Yes or No Rican, etc.)	0- 14. Ra	ce - American ock, White, etc	
urs eft.		1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 1 1 If Yes, Give Yeer or Detes:	No		1 □ Yes 2 💢	No Specia	fy:		Speci	b: Wh	ite
be filed within 72 hours efter death with the Manylar that Hygiene. Indicates than "natural", or items 23a or 28a-f show event, the Medical Examinar mant be notified at Be Completed by Funeral Director	3	15. Decadent's Ed			16a. Dece	dent's Usuel O	ccupetion			16b. Kind of 8	Business/Indus	stry
buld be filed within 72 ho Mental Hygiena. Inked other than "naturi atic event, the Medical To Be Completed		(Specify only highest gre- Elementery/Secondery (0-12)	de completed) College (1-4or 5	54)	(Give life.	kind of work d DO NOT use n	one during me etired)	ost of work	king			
d with	5	12	Conege (1-401)	5+)	Sup	perviso	r			Retail	Grocer	y/Safeway
tai Hygi d other event,	1	17. Fether's Neme (First, Middle, Lest)					18. Mol	her's Nem	e (First, Middle	, Maiden Sume	me)	
should be nd Menta marked umatic ev	2	Samuel Oscar Eck	ard				M	ary E	lizabet	th Winds	or	
and and series		19a. Informent's Neme/Reletionship (7								ber, City or Town		ode)
is 1 end if Health item 27 other tr	_	Claudia C. Eckard	1	lest Bt				, Wal		1D 20602		
Pages 1 nent of H int: if its	2	20a. Method of Disposition 1 ☑ Buria 2 ☐ Cremetion 3 ☐	Removel from State			osition (Name of metory or other			Date		- City or Towr	
	-	4 □ Donation 5 □ Other (Specify)	Irir					-18-98	Waldorf	, Mary	land
permit. Departr Importu any inj	- 1	21. Signature of Fundful Service Licen	u ska u	. 1	1	2. Neme end A luntt Fi		11	Inc.			
	1	Mark G. Broke	awn Moods	3	F	0. B	ox 156	, Wal	dorf, N	1D 20604	-0156	
•		23e. Pert1. Enter the disease, or comp shock, or heart feilure. List only	plicetions thet caused one cause on each li	d the death. ine.	Do not en	ter the mode of	dying, such	es cardiec	or respiretory	errest,	l Ir	pproximete itervei Between Inset and Death
Physician /Medical		Immediete Cause (Finel										
Examiner		diseese or condition resulting in death)	. Contact				chest					
<u> </u>	5			Due to (or	es a conse	quence of):						
ate be axecuted hysician end the burial-fransit		•	b	Due to /or	es e conse	quanca of):					1	
be axecuted ician end burial-fransit	LA	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		D04 to (01	93 9 001139	querice or,						
ysicia ysicia ie bur	3	Ceuse (Disease or injury that initieted events	c	Due to (or	es a consec	quence of):						
uffica os th		resulting in death) Last		,							1	
int the death certifical by the attending philetached for use es the Physician/Med			d	-							1	
death be att	F	Pert II. Other significant conditions of	ontributing to deeth b	out not resul	Iting in the u	inderlying caus	e given in Pe	rt I.	23b. Dfc	l tobacco use c	ontributa to ti	he cause of death?
at the									1	Yes 2 No	3 Probe	bly 4 Unknow
as the	5										T 041-141	
The law requires sate hes been sign page 2 should be									24e, We	s en eutopsy formed?	avail	e eutopsy findings able prior to oletion of cause
2 2 3	1								INSPE	CTION	of de	
The page	5									Yes ZN No	10	Yes 2□ No
ysician: The list certificata he director, paga	2	25. Wes case referred to medical exeminer?	Hospital:				Γ.	ece of Dee	th (Check only	one)		
5 5 5		Yes 2□ No	Hospitel:			nt 3 DOA		Nursing H		sidence 6 0		
ding Ph h. After thi funeral		27. Menner of Deeth 1 □ Naturel 5 □ Pending	28e. Dete of Inju	y Year)	28b. Time o		Injury et Work?	EINA		how injury occu		
Attending r death. ector: Afte by the fune	0	2 ☐ Accident Investigation 3 ☑ Suicide 6 ☐ Could not be	3-17		22135		1 ☐ Yes 2	MR 140	29f Location	(Street end Nun	her or Rural I	Poute Number
244 E		4 Homicide determined		City or To	own, Stete) 40%	GARNER.	AVE					
pitar Durs filled		29a. Certifier 1□ Certifying Ph	ysician: To the best		ME deal	h occurred at t	he time dete	and niece		CHALES		
To the Hospital or Attent within 24 hours effer deal To the Funeral Director: completaly filled in by the Medical Certifical	1	(Check only one)	inar: On the basis or end menner st	f exeminetic	on end/or Ir	vestigation, in	my opinion, d	eeth occu	rred et the time	, date end plece	, end due to the	ne cause(s)
To the Hospital within 24 hours e To the Funeral E completaly filled		29b. Signeture and title of certifier				29c. L	icense numbe	er		29d. Date sign	ed (Month, De	ey, Year)
- 5 - Ö		Donald D. a	night MD				0 11 -	3		MADOTT	16 100	20
	-	30. Neme end eddress of person who		death (Item	23e) (Tuno		C.M.E	J. 6		MARCH	16, 199	30
	1	Ann Dixon M.D.	.c.npiotou oudoo di C	Som from			mot	Ral+	imoro	Marylan	a 2120	1
		31. Date filed (Month, Day, Year)		rer's Signati		LUIII OL	rcer,	LULL.	THOTE!	run A Ton	4 6160	

Registrar

MAR 2 0 1998 Jali Shudeor Randall



TO BE COMPLETED BY FUNERAL DIRECTOR

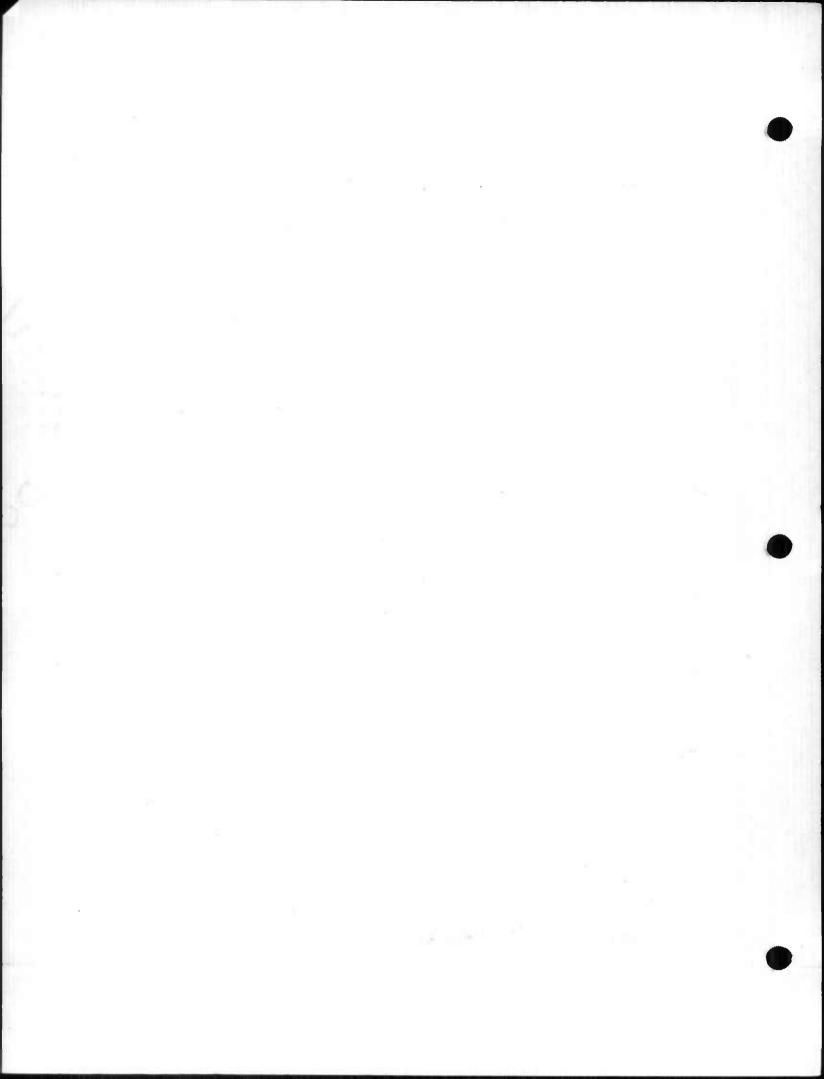
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed willim 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Hydiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPIT	TO THE FUNERA	IMPORTANT:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)
MAR 1 8 1998

-	FOR STATE REGISTRAR		STATE OF I	/ARYL			TMENT O				MEN	TAL HYGIENI REG. NO.	E		
i	1. DECEDENT'S NAME (First,	Middle, Last)									2. D	ATE OF DEATH			3. TIME OF DEATN
1	Frances	Mildr	ed Ean	es							M	arch 15	1	958	8:00AM m
I	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. las	birthday)	IF UNDER 1 Y	EAR	IF UNDER	24 HRS.		ATE OF BIRTH		8. BIRTH	NPLACE (State or Foreign
	218-24-3738		1 M 2 X F	7	70	YAS.	MONTHS D.	AY8	HOURS	MIN.	Ma	y 20, 19	27	Vi	rginia
	9e. FACILITY NAME (If not in:	stitution, give s	treet and number)				9b. CITY, TO	WN C	OR LOCATI	ON OF DI		, 20, 17		NTY OF D	
ı	Glade Valle	ev Nur	sing & R	ehab	. Ct	r.	Wal	Lke	ersvi	11e				Fred	erick
I	RESIDENCE OF DEC														
	10e. STATE	10b. COUNT				10c. CIT	Y, TOWN OR I								10d. INSIDE CITY LIMITS?
I	Maryland		Frederic	K			Wa	яTк	cersv	1116	5				1 YES 2 NO
	10e. STREET AND NUMBER							100	. ZIP COD	Ε			10g. CIT		WHAT COUNTRY?
ı	500 Chap	el Cou	rt, Apt.	104							2	1793		U.	S.A.
I	11. MARITAL STATUS		12. WAS DECEDEN									RIGIN? (Specify Yee	or No-	14. RAC	E — American Indian,
ľ	1 Never Merried 2		FORCES? 1			10			ecify Cube			erio Ricen, etc.)			k, White, etc.
	3 X Widowed 4 Divo	rced													White
I	15. DEC	EDENT'S EDU highest grade	CATION completed)		(G	ve kind of	USUAL OCCL	JPATIO	ON ost of working	na		16b. KIND OF BUS	INESS/INC	DUSTRY	
	Elementary/Secondery (0	1-12)	College (1-4 or 5	+)	lite.	Do NOT u	se retired.)								
I	6					hom	emake					own	home		
I	17. FATNER'S NAME (First, MI								16. MOT			irst, Middle, Maiden	Surname)		
1	Edward Hod											Hall			
۱	198. INFORMANT'S NAME (7)				198							Number, City or Town			
1	Judith Ean		ugnter							walk	cer	sville,			
ı	20e, METNOD OF DISPOSITI 1 ☑ Buriel 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other	n 3 🗆 Rem	oval from State				of disposition of the control of the						dsbo		
ı	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE /	1			22. NA	ME A	ND ADDRE	SS OF FA	CILITY	Hartzler	- Fire	0 × 0 1	Uomo
ı	W allow	. 1	01/	101	1 ,		1.01	, c	S. Ma	in C	3+				21798
4	Corror	une (V. New	16 11	N										7 21790
ı	23. PART I. Enter the di ahock, or he	eart failure.	complications the List only one car	it eatised	the de ach line	eth. Do	not enter th	s mo	de of dy	ing, suc	h ss	cardiac or respi	ratory sn	rest,	Approximats Interval Between
I	IMMEDIATE CAUSE (Fin	nel		11.		r	Ren		1						Onset and Death
I	resulting in death)	\rightarrow	a	- 1.7	IOV	110	1 en	~	1	えしい) ~ (lyear
ı			DUE TO	(OR AS A	CONSE	DUENCE O	7	-							
I	Sequentially list conditi	lona,	b	(OR AS A	NIS	DUENCE O	uS16	1	/						years
I	If any, leading to imme- cause. Enter UNDERLYI		202.10	11		1	1								21.15
	CAUSE (Disease or inju- that initiated events		cDUE TO	(OR AS A	CONSEC	DUENCE O	PIOL	u	-16-						years
1	resulting in death) LAS	т 📗		AL	1 0	111	244		10	Di	Co	0,10			110111
I			d	1//	Ne	000	2000		LLC.	171	<u>ــــــــــــــــــــــــــــــــــــ</u>	or de			14000
ı	PART II. Other significa	ondition	s contributing to	death b	ut not r	eaulting	in the unde	rlyin	g cause	given in	Part	I. 24a. WAS AN PERFOR		240	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
H	COX	7()										1 YES 2			COMPLETION OF CAUSE
ı							,						OC		OF DEATN?
1	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE C	F DEA	TH Y	ES X NO) [UNC	CERTAI	N [3			Transf Stand
H	25. WAS CASE REFERRED TO	O MEDICAL			26. PLAC	E OF DEA	TN (Check only								
ı	EXAMINER?		HOSPITAL:	☐ ER/Outp	patient 3	□ DOA	OFFIER:	a Hon	ne 5 🗆 R	eeldence	6 🗆	Other (Specify)			
1	27. MANNER OF DEATH		28e. DATE Of	INJURY		28b. TIN					28d.	DESCRIBE NOW I	NJURY OC	CURED	
1		Pending Investigation	(MOTRIT, 2	rear)		livi.	JURY		ORK? YES 2 [_ NO					
1	2 O Cultida	Could not be	28e. PLACE (OF INJURY	— At ho	me, lerm,	street, fectory	, offic	ie e		281.	LOCATION (Street a	and Numbe	r or Rural	Route Number,
1		determined	bulluling	are: lober	снуј							City or Town, State)			
	290. CERTIFIER	TIFYING PNYS	ICIAN: To the best o	f my know	rledge, de	eth occur	red at the time	, date	end place	e, end due	to th	e cause(e) and mar	mer en ste	ted.	
	anni														s) end manner es stated.
	29b. SIGNATURE AND LIKE	- fresh													
	- WA	HILL	KAI						17)	TO THE PROPERTY OF THE PROPERT	(5	6	ZVO. DAI	SIGNE	O (Month, Day, Year)
1	30. NAME AND ADDRESS OF	LEERSON WA	IO COMPLETED CAL	SE OF DE	ATN /ITE	M 27) /Km	Print	T.T.*	111	100	, <u> </u>	1.0	14.5	110	1010
	122	chom		Mars			(10	MI	llia	my H.	J (ohnson	M. H.	21	7017

32. MEGISTRAR'S SIGNATURE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle 1 ast) 3. Time of Deeth 02: 46 PM 2. Dete of Deeth **Physician** ERDECKY MARCH MARTHA ANN /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth DOCTORS HOSPITAL PRINCE GEORGES PRINCE GEORGES LANHAM 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Days Months 1□M 2□F 208-20-7203 72 Yrs Director 1925 Pennsylvania 5, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-1 show 10d. Inside City Limits the Medical Examiner must be notified at Prince Georges Director Nes 2□No New Carrollton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 6219 85th, Pl. 20784 "natural", or items 23a U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Maritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. filed within 72 hours after 1 Never Married 2 Married If Yes, Give 2 Yeer or Dates: 1 ☐ Yes 2 ☐ No Specify: p Specify: Caucasian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) Coilege (1-4or 5+) OWN Home Homemaker marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Pages 1 and 2 should be 1 nent of Health and Mental Michael Erdesky Susan Kaza 19e. tnforment's Name/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum 90026. 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosemarie Connors (Niece) 11703 Caplinger Rd. Silver Spring, MD 20984 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Calvary Cemetery 3/21/98 Punxsutawney, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Neme end Address of Fecility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one seuse on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Cause (Finei disease or condition resulting in deeth) /Medical . HYPERTENSIVE ARTERIOSCLEPETIC CARDIOVASCULAR **Examiner** Due to (or es e consequenca of): Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequença of) certificate be exec Due to (or es e consequenca of) Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably SCHIZOPHRENIA py 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? The law D000 2 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 1 Yes 2 □ No Be 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA 差 27. Menner of Death 28c. Injury et Work? Affiler 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be 3 Sulcide Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) tilled in th 4 Homicide 6 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner as stated. Medical Examiner: On the basts of examination end/or Investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) To the F å

29c. License number

HOSPITAL

29d. Date signed (Month, Dev. Year) MAROH 19, 1998

DRIVE, CHEVERLY, MARYLAND 20785

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

of Vital Records,

Division

State

31. Dete filed (Month, Dey, Yeer) MAR 2 U 1998

MARIO

32. Registrer's Signeture

JR

MP

3001

30 Name and eddress of person who completed cause of deeth (Item 234) (Type, Print)

GOLLE

Registrar

Mar 20 998 John Marker Parker

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Aonth EOR March 10:55 PM /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince George's Hospita aurel _dure 6. Sex 14 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Deta of Birth (Month, Day, Year) **Funeral** Months Deys Hours Yrs Director JUNE 14, 215-03-4319 MARYLAND 1911 Usual Residence of Decedent tha Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumetic event, the Madical Examinar must be notified at 1 ☐ Yes 20XNo Directo MARYLAND PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? with permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health end Mental Hygiene. Important: If Item 27 is merked other than 'natural', or Items 23s any Injury or other traumatic avainations. 5013 54TH AVENUE Funeral 20781 UNITED STATES 12. Wes Decedent Evar in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) Rece - Amarican Indian, Bleck, White, atc. 11. Marital Stetus 1 Yes 2 □ No If Yes, Giva Yaar or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 21 No WHITE þ Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MECHANIC AUTOMOTIVE 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be JACOB EURICH 2 ANNA MARY SORG 19e. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 54TH AVENUE, HYATTSVILLE, MD EUGENE P. GARRITY, BROTHER-IN-LAW 20781 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 🛱 Crametion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) FORT LINCOLN CREMATORY 3/16/98 BRENTWOOD, MARYLAND 22. Name end Addrass of Facility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MD 20722 Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner to (or es e consequence of): Examiner bunel-transit certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Disease or Injury that Initiated events resulting in deeth) Last pue Due to (or as a consequence of): physician Physician/Medical the Due to (or as a consequence of): USB Pert II. Other algorificant conditions contributing to death but not resulting in the 23b. Did tobacco use contribute to the cause of death? the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Eslaro þ 24b. Were autopsy findings evellable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed peen has 2 No certificata 1 ☐ Yes 1 Yes 20 No of attending Physician: eftar death.

Director: After this certifica 25. Wes cese referred to medical Be 26. Plece of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28e. Date of Injury (Month, Day Year) funeral 27. Menges of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide pelli • Funeral C Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the best of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29a. Certifier Medical pletaly (Check only one)

Box 68760 Division of Vital Records, P.O.

within 2 To the

State Registrar

29b. Signeture end title of contain

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 43332 31. Dete filed (Month, Day, Year)

32. Registrer's Signature Set Mudeon Revolate 29c. Licansa number

29d. Date signed (Month, Day, Year)

208

Terms with the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

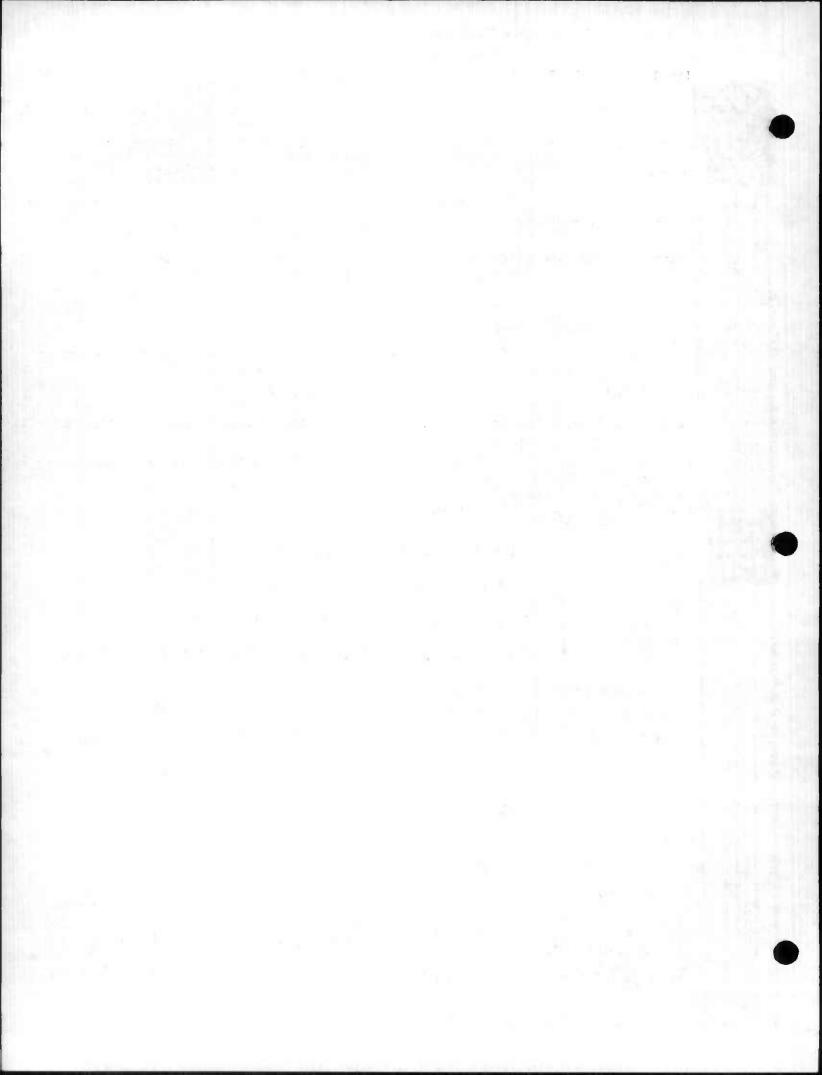
State of Maryland / Department of Health and Mental Hygiene ()

						Certi	ficate of		R	eg. No.	1 U	033
г	Physic	ian	1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month		Year	. Time of Deeth
	/Medi		VINA B. EGE						03	Day 22	98	9:45 am
	Examir	ner	4a. Fecility Name (If not institution, give	100 000 000 000 000				4b. City, Town, or I		4c. County		
			Caroline Nursing				f Under 1 Year	Denton If Under 24 Hrs.			roline	
	Funeral Director		390-07-3833	M 2ŽF	90		Aonths Deys		March I), 1908	9. Birthpiece Country) W1SCO1	(State or Foreign
	and w		Usuai Residence of Decedent 10e. State 10b. County		10c. City, To	wn or Locat	ion				10d.	Inside City Limits
	Ba-f eho	Director	Maryland Caroline		,,,	_	nton					1 □ Yes 2 No
	ath with the	ral Dire	10e. Street and Number 25191 Adams Landin	g Rd.			10f. Zip Code 2162			10g. Citizen of Whet Country? USA		
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show my highly or other traumatic event, the Medical Exercises must be notified at ance.	by Funeral	11. Merital Status 1 □ Never Married 2 □ Merried 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			s Decedent of es, specify Cut Yes 2 No	Biac	14. Rece - American Indian, Black, White, etc. Specify: White			
5-0	72 h	etec	15. Decedent's Educ (Specify only highest grade		16	ie. Deceden	t's Usuai Occu	ipation a during most of wor ed)	kina	16b. Kind of Bu	siness/Indust	ry
121	within ene. then "	Completed	Elementery/Secondery (0-12)	Coilege (1-4or 5	+)		<i>NOT</i> use retire maker	ed)				
	Hygin ther		17. Father's Name (First, Middle, Last)			Home	maker	18. Mother's Nan	ne (First, Middle, M	Aeiden Sumem	e)	
an	d be sented	To Be	William Charles Ba	rrows					nn Reynol		-/	
Maryland	shou mar	-	19e. fnformant's Name/Relationship (Ty)	pe, Print)	19	9b. Maliing /	Address (Stree	et end Number or Ru	ral Route Number	City or Town,	State, Zip Co	de)
	alth e 27 le		Sharon Slaughter/d	aughter	2	5191	Adams I	Landing Ro	l. Dento	m MD	21629	
ore,	Peges 1 and 2 ment of Health earth of Health eart: if item 27 is ury or other tra		20a. Method of Disposition		20b. Place cemei	of Dispositi	on (Name of ony or other pla	ace)		20c. Location -		State
E	Pege nent nr. H nry or		ty⊡yBuriai 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stete			o Cemet		3/25/98	Greens	boro, l	MD
Baltimore,	permit. Pege Department of Important: If eny Injury or once.		21. Signature of Funeral Service License	· Cl	./	22. N	leegie	ess of Fecility & Helfen	oein Fune	eral Ho	me, P.	
100			23a. Part1. Enter the disease, or compli-	cations thet caused	the death. De			Sunset Ave				1639 proximate erval Between
į	Physician /Medical		Immediate Ceuse (Finet disease or condition	e cause <i>on</i> each iir	10.			art f			On	erval Between set and Death
	Examiner	<u>.</u>	resulting in deeth)		Due to (o) as	a conseque	nce of):	7)	et l			
	uted d ansit	Examiner	De b	•	Due to (or as		non offi	- M-1			-	
o,	icate be executed physician and s the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or as a	a conseque	nce org.				1	
68760,	yslcig	Medical	Cause (Disease or injury that initiated events		Due to (or es e	consequer	nce of);	<u> </u>				
	ing ph	Med	resulting in death) Last		,		,				1	
Box	eeth cert ettendin I for use	Physician/	d									
	e de the s	ysic	Pert II. Other significant conditions con	tributing to death bu	rt not resulting	in the unde	rlying ceuse g	iven in Pert I.	23b. Dld to	bacco use cor	tribute to the	cause of death?
, P.O	that the ned by detect	by Ph	Alzheim	er's de	meni	tis			1 🗆 Ye	20 No	3 Probabl	y 4 Unknow
Records,	The law requires that the deeth certificate be executed the bes been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit	Completed b							24a. Wes a perform	n autopsy ned?	availat	autopsy findings ble prior to etion of cause
Re	The lew ate hes page 2	E O							1□ Ye	s 2 No	1 🗆 Ye	
Vital	- 4	0	25. Wes cese referred to medical					26 Plece of Des	th (Check only on	1	1016	9 20110
>	Physician: this certific ral director,	OB	examiner?	ospitai:	nt 2 ER/0	Dutpatient	3 DOA OI	ther	ome 5 Reside		er (Specify)	
on of	Attending Physic death. •ctor: After this by the funeral di	itlon: T	27. Menner of Death 1. Netural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	y 28b	. Time of Injury	28c. fnju		28d. Describe ho			
Division	To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this of completely filled in by the funeral directions.	Certification:	3 Suicide 6 Could not be determined	28e. Piace of Injubuliding, etc	iry - At home, . (Specify)	ferm, street	, factory, office		28f. Location (St City or Town		er or Rural Ro	ute Number,
	e Hospita 24 hours e Funere	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination a	ge, death od and/or invest	curred at the t tigation, in my	ime, date end piace opinion, death occu	, and due to the carred at the time, de	ause(s) and me ate and place, a	nner as stated and due to the	1. cause(s)
	To the To the somp	Me	29b. Signature end title of certifier	111	3.		29c. Licen	se number	2	9d. Dete signed	(Month, Day	Year)
				WKI			104	7534	}	3/2:	198	
			30. Neme and address of person who con	mpleted cause of de	eath (Item 23a) (Type, Prir	nt)			3,00	, , , ,	
			Watik Zaki Shors	Cinical	9201	Market	St. n.	enton m	d.			
	Sta		31. Date tiled (Month, Day, Year)		r's Signature	1						
	Registr	ar	14 '98		walled sor	r-Hand	222_					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Item 1 Per PHY film	G759 5=13-98	rja		ificate of	Health and Death	,	Reg. No.	10036
Physic /Med Exami	ical	Decedent's Neme (First, Middle JONAS JONUS FOUGY Facility Neme (If not institution)		er)			4b. City, Town, or	2. Dete of De Month March Location of Deet	Dey 18, 19	
Funeral Director	1.0	Washington Adve 5. Social Security Number 019-66-5622		Age (In yrs. la	ast birthdey)	If Under 1 Yeer Months Deys		8. Dete of Bi	ey, Year)	mery 9. Birthplace (Stete or Foreign Country) Haiti
pu ≥		Usuel Residence of Decedent 10a. Stete 10b. County Maryland Prince	Georges	10c. City	Town or Local					10d. Inside City Limits 1 1 Yes 2 □ No
th with th	al Director	10e. Street end Number 12609 Spriggs R	equest Cou	rt		10f. Zip Code 20721			10g. Citizen of Wi	het Country?
be filed within 72 hours effer death with the Maryland nial hygiene. Id hygiene, od other than "natural", or items 23s or 28s-f show event, the Madical Exam of must be notified at	by Funeral	11. Maritel Stetus 1 Never Married XXMarri 3 Widowed 4 Divorced	12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Dete	s? XIXIo		as Decedent of I Yes, specify Cub	Hispenic Origin? (S ean, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	14. Rece Bleck Specify:	- American Indien, , White, etc. Black
d within 72 hours of gione. r then "neturel", or	Completed	15. Decedent (Specify only highes Elementery/Secondery (0-12) 1.2	's Education it grade completed) Coilege (1-4e	or 5+)	16e. Decede (Give k life. De Busine		petion during most of world)	king	16b. Kind of Bus	
d 2 should be filed within the and Mental Hygiene. 7 Is marked other than traumatic event, the Mental traumatic event.	To Be Co	17. Fether's Neme (First, Middle, L Elie Fougy	Last)				Jolicia	Jeudi	o, Maiden Sumeme)
permit Pages 1 end 2 should Department of Health end Mer Important: If item 27 is marke any injury or other traumetic		19a. Informant's Name/Relationsh Ghislaine Fougy 20e. Method of Disposition 1 \(\sum_{\text{Burial}} 2 \sum_{\text{Cremetion}} \) 4 \(\sum_{\text{Donation}} \) 21. Sofitive of Funeral service I.	- Daughter 3 □Removel from Ste	20b. Pi	12609 eca of Dispos imetery, cremic of He	Spriggs ition (Name of etery or other ple	Request	Court,	20c, Location - C	otate, Zip Code) ville, MD 2072 Sity or Town, Stete pring, Marylan
Physician /Medical Examiner	4	immediate Ceuse (Final disease or condition resulting in death)	pomplications that caused by one cause on each			51	E.MA	or respiretory	arrest,	Approximate interval Batween Onset and Death
The law requires that the death certificate be executed at has been signed by the ettending physician and page 2 should be detached for use as the buriel-transit	in/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	" Mot	Due to (or	es e consequ	ence of):	no ck	PICUR		Years
es thet the deeth certific igned by the ettending p be detached for use as	by Physician/Me	Pert ii. Other significant condition			Iting in the und		ven in Pert i.		. ^	iribute to the cause of death?
e law requires has been sig ge 2 should by	Completed b	24ck4r	DE	CVI	BIJA	2			s en eutopsy ormed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
ysiclan: is certific director,	To Be Cor	25. Wes case referred to medical examiner? 1 \(\text{Yes} \) 25. No	Hospital Vinp	atient 2□ I	ER/Outpetient	3□ DOA Ot	26. Pieca of Deher:	eth (Check only	Yes 2 XINo one) idence 6 □Othe	1 Yes 2 No
To the Hospital or Attending Physician: The law requires the within 24 hours effer death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be to	Certification:	27. Menner of Death Naturel 2 Accident 3 Suicide 4 Homicide 27. Menner of Death 5 Pending investig 6 Could n determi	ation of be 28e. Piece of		28b. Time of injury me, farm, stree	28c. inju Wo M 1 L	Yes 2 No	28t. Location	how Injury occurre (Street end Number wn, Stele)	r or Rural Route Number,
he Hospital in 24 hours he Funerel pietely filled	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the be Examiner: On the besis end menner	s of examineti	viedge, deeth on end/or inve	occurred et the ti estigetion, in my	ime, dete end piece opinion, death occu	, end due to the irred at the time	ceuse(s) and man , date and place, al	ner es steted. nd due to the cause(s)
Vithi Tota	M	29b. Signeture and title of certifier	be			29c. Licen.	9971		03/18	(Month, Dey, Year)
		30. Name end eddress of person v	who completed cause of	of deeth (item	23e) (Type, P	rint)	(423 C	o mA	J. S &. C	m 820912



State of Maryland / Department of Health and Mental Hygiene

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7 is marked other than "natural", or itema 23a or 28a-1 a traumatic evant, the Medical Examiner must be not the Directo

permit. Pages 1 and 2 should be filed within 72 hours after death vibralisment of Health and Mental Hyglene.
Importment: if items 27 is marked other than "natural", or items 23, any injury or other traumatic event, the Mende of Experient many injury or other traumatic event, the Mende of Experient man. Funeral Baltimore, Maryland 21215-0020 þ Completed **Physician** /Medical Examiner Examiner physician and s the bunal-trensit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physiclan/Medical 88 980 the signed by t þ should b Completed page 2 s certificate or Attending Physician: director, Be Certification: To this After this hin 24 hours after death. the Funeral Director: At apletely filled in by the fu death. the Hospital edicai To the I within 2 To the I 0

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Bruce A. Friedman MARCH 7, 1998 1:40 PM 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ROCKVILLE
If Under 24 Hrs.
Hours Min.

Min.

Month, Day, Year)
04/17/1949 ADVENTIST HOSPITAL SHADY GROVE MONTGOMERY If Under 1 Yaar Birthpiace (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 1**X**M 2□ F Months Days Yrs. WASHINGTON, D.C. 216-50-8303 48 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No MARYLAND MONTGOMERY GAITHERSBURG 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 30 GOODPORT COURT 20878 UNITIED STATES OF AMERICA 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritai Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 20 Married 1 ☐ Yas 2 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Coilega (1-4or 5+) 5+ JUVENILLE COUNSLER STATE OF MARYLAND 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) MEYER FRIEDMAN SHIRLEY KESSLER 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) LOUIS S. FRIEDMAN/WIFE 30 GOODPORT COURT, GAITHERSBURG, MARYLAND 20878 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) JUDEAN MEMORIAL GARDENS 3/9/1998 OLNEY, MARYLAND 22. Nama and Addrass of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND implications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, y one cause on each line. Approximata Interval Between Onsat and Death 23a. Part1. shock, or heart fa Immediata Causa (Final disaasa or condition rasulting in daath) RESPIRATORY FATILIRE 5 MINUTES Dua to (or as a consequence ot) HYPOXIC-ISCHEMIA OF BRAIN STEM 6 DAYS 12 HRS Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) ELEVATED INTRACRANTAL PRESSURE 6 DAYS 12 HRS. Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part Ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performad? completion of ceuse of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona) 25. Was cesa ratarred to medical Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No Hospital: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred

1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Sulcide 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29a. Cartifiar t 😭 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one)

29b. Signatura and title of certifian

MAR 20 1998

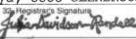
8631

29d. Data signed (Month, Day, Year) March 07, 1998

30. Nama and addrass of parson who complated causa of daath (Itam 23a) (Type, Print)

20814-2608 8806 GLENBROOK ROAD, BETHESDA, MARYLAND Dr. Ayub Kahn Ommaya, 31. Data tiled (Month, Day, Yaar)

State Registrar



M.D

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month

Physician /Medical Examiner

John G. Fanfani 4e. Facility Name (If not institution, give street and number) 3125 Beckenham Court

1. Decedent's Name (First, Middle, Lest)

March 4b. City, Town, or Location of Death Silver Spring

3. Time of Deeth 1998 9:45 AM

Funeral Director

28a-f show

6

"natural", or items 23a

permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite, any Injury or other traumatic event, the Medical Examina

Physician /Medical

Examiner

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certificate

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After

To the Hosp within 24 ho To the Fune completely fi

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director

The lew requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vitai or Attending Physician: Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

the Medical Exponence must be notified at

Funeral

by

Completed

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deeth

201-14-0792 Usual Residence of Decedent 10a State 10h County Director

5 Social Security Number

10c. City, Town or Location

Yrs.

7. Age (In yrs. lest birthday)

74

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Montgomery Birthplace (State or Foreign Country)

Nov. 18, 1923 Washington, DC 10d. Inside City Limits

11,

4c. County of Deeth

Maryland

Montgomery

1⊠M 2□ F

Silver Spring

1 Yes 2 No 10g, Citizen of What Country?

10e. Street and Number

11 Maritai Status

3125 Beckenham Court

20906 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10f. Zip Code

Administration

United States 14. Race - American Indian. Black, White, etc.

Year or Dates: WW II

1 ☐ Yes 2 ☒ No Specify:

Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

1 Never Married 2 Married

3 ☑ Widowed 4 ☐ Divorced

College (1-4or 5+)

1 TYes 2 No

Was Decedent Ever in U,S. Armed Forces?

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry Construction

17. Father's Name (First Middle Last)

Italo Fanfani

18. Mother's Neme (First, Middle, Maiden Surneme) Mary Fisher

19a. Informant's Neme/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Esther F. Fanfani/Daughter

20b. Place of Disposition (Neme of cemetery, crematory or other place March 13, 1998

9553 Red Apple Lane, Columbia, Maryland 21046 20c. Location - City or Town, State

20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

Montgomery Crematorium, Inc.

Bethesda, Maryland

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

22. Name end Address of Facility
Robert A. Pumphrey Funeral Home/ Chase, Inc.

M00198

23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)

Coronary Artery Disease Due to (or as e consequence of)

Years

Due to (or as a consequence of):

Due to (or as a consequence of)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3⊠ Probably 4 ☐ Unknown

24e. Wes an autopsy

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 X Yes 2 □ No

28e. Date of Injury (Month, Day Year) 5 Pending investigation

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 Yes 2 No

26. Place of Death (Check only one)

29a. Certifier (Check onh

27. Menner of Death

1 Natural

3 ☐ Suicide

2 Accident

4 Homleide

1 🖸 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature ar

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and endress of parson who completed cause of deeth (Item 23a) (Type, Print)

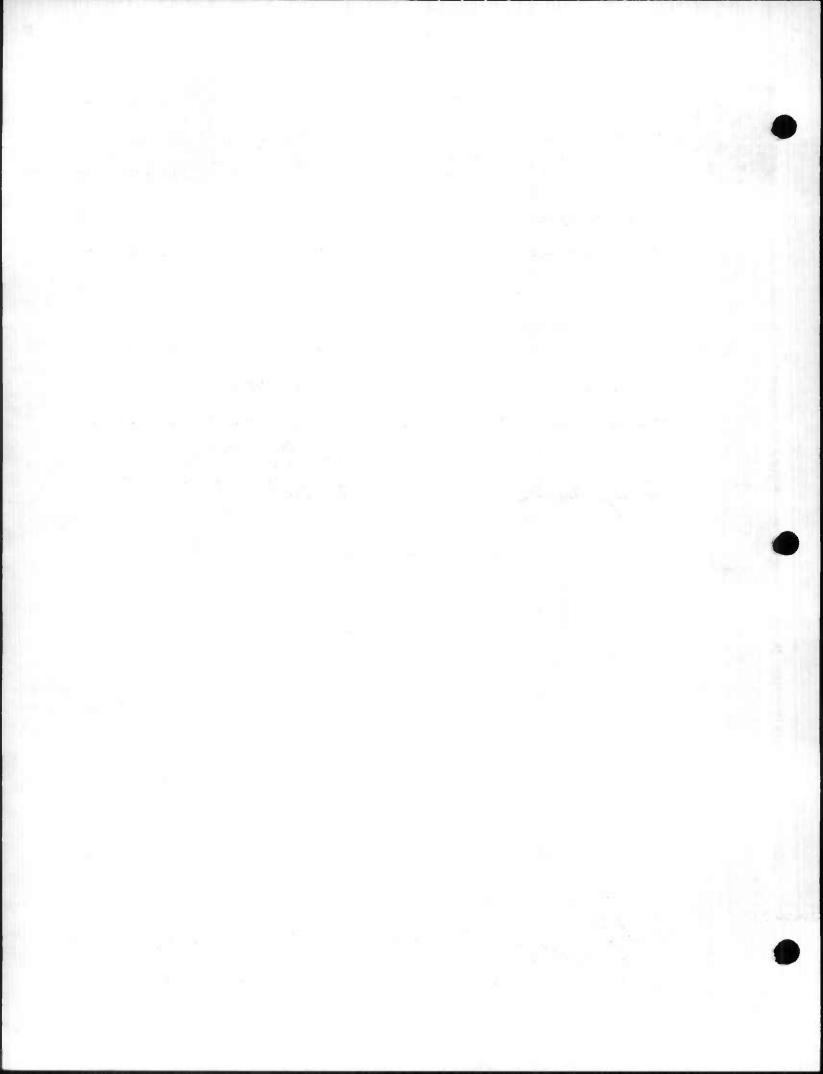
Goval, M.D. 18111 Prince Philip Drive, #328, Olney, Maryland Naku1

State Registrar 31. Date filed (Month, Day, Year) MAR 16

6 Could not be determined



DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical			JO	HN		FIFF	ΙK			MARCH	12,19	98 1	1:13A.M	
Examiner	48	Facility Nama ('If not institution	, giva street and nun	nber)				4b. City, Town, or	Location of Dea	th 4c. County	of Death		
		3101 S.L	EISURE	WORLD BLV	D				SILVER S	PRING	MONTO	OMERY		
uneral	5.	Social Security N	Number	6. Sax	7. Aga (In yrs.	lest birthday) If Under Months	1 Yaar Deys	If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D	irth	9. Birthplace	e (Stete or Foreig	
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at be notified at		MD.	MONT	GOMERY		S	ILVER	SP	RING				1 Yas 2 □ No	
Director	10	e. Street and Nu	mber				10f. Zip	Coda			10g. Citizen of V	. Citizen of What Country?		
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þ		3 Widowed		If Yas Giv	atas: KOR	EAN	1 ☐ Yes	2 X No	Specify:	Specify: WHITE		TE		
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	(Specify only highest grade completed)			Aor Su	(Giv. lifa.	DO NOT u	rk dona se retire	during most of word)	rking					
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sicia	Pa	art II. Other etgni	ficant conditio	ns contributing to de	eath but not rase	ulting in tha	underlying o	ausa gh	ven in Pert I.	23b. Dic	tobacco uee co	ntributa to th	e cause of deat	
detacr										1	Yee 2□No	3 Probab	oly 4 Unkno	
ate has been signed by the ate page 2 should be detached for Completed by Physicia										24a. We	s en eutopsy formed?	24b. Wara	autopsy findings	
s bee	-									per	iomed:		letion of cause	
page 2										N	Vac office	An.		
S pag										1	Yas 2□No	MAN	'es 2∐ No	

Division of Vita

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificietly filled in by the funeral director,

Be

Certification: To

25. Was casa rafarred to madical examiner? 1⊠ Yes 2□ No

3 Sulcide

29a. Certifier (Check only

4 Homicida

27. Mannar of Death

1 Naturel

2 Accidant 5 Pending invastigation

6 Could not be detarmined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) WOODS 28d. Dascribe how Injury occurred 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, daath occurred at the time, data and placa, end dua to tha causa(s) and manner stated.

26. Plece of Deeth (Check only ona)

29b. Signature and titla of certifian

29c. License number

29d. Dete signed (Month, Day, Year)

O.C.M.E.

MARCH 13, 1998

and addrass of person who completed cause of daath (Itam 23a) (Type, Print)

with

111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signetura

Fundamentary

State Registrar

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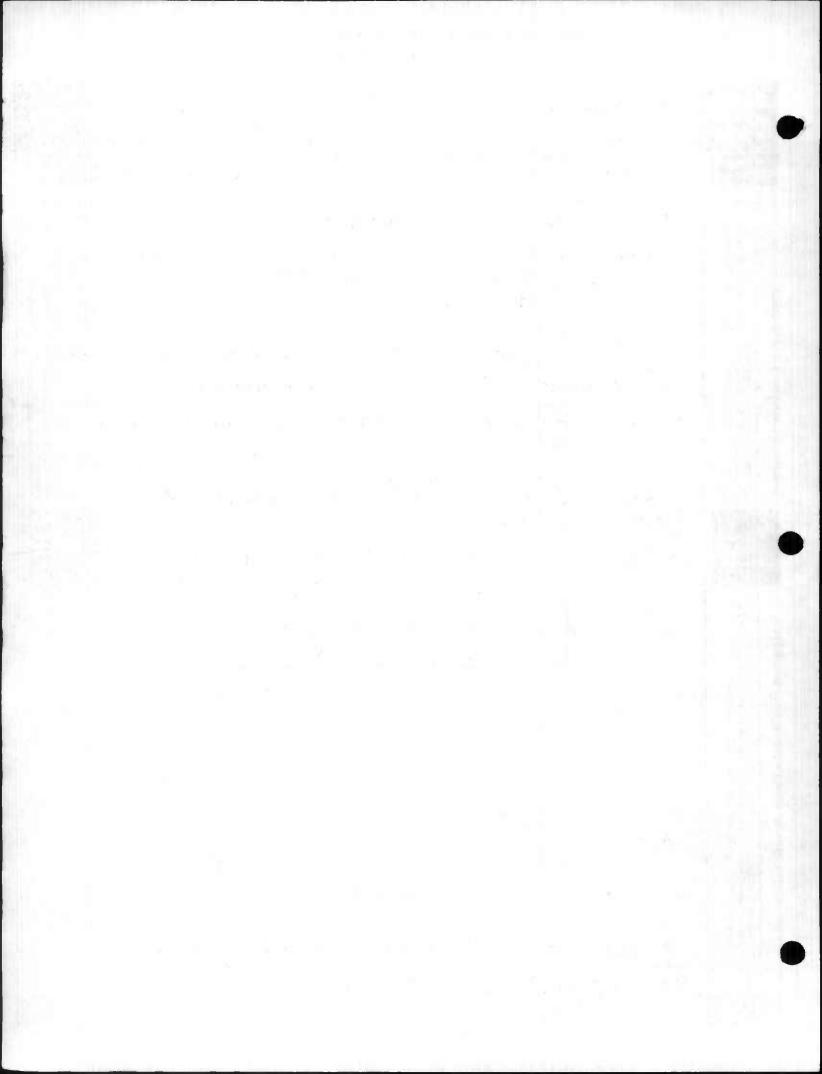
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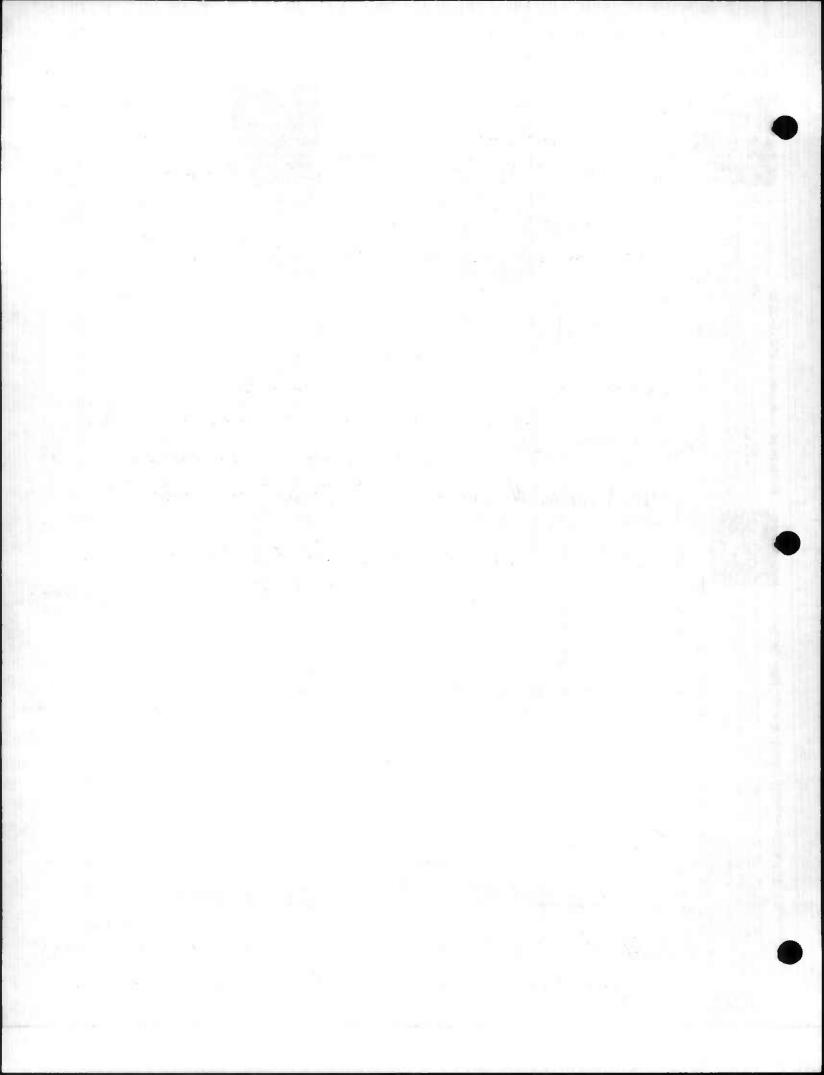
State of Maryland / Department of Health and Mental Hygiene 9 8

					Certificate o	f Death	Re	eg. No.	1004	, 0
	Dharia		1. Decedent's Name (First, Middle, La	· ·			2. Date of Deat	h	3. Time of	Death
	Physic /Medi		Robert Frank Fior	ramonti			March 1	6, 1998	4:16	PM
	Exami		4a. Facility Name (If not institution, give			4b. City, Town, or Lo		4c. County o	Death	
			Holy Cross Hosp	ltal		Silver Sp			tgomery	
	Funeral Director		711 7221	Fig. 7. Age (In yrs 7.6) 7. Age (In yrs 7.6)	Months Day	ar if Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, Oct. 15	Year) 1921	9. Birthplaca (Stata of Country) Wash., DC	r Foreign
	pue ***		Usual Residance of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. inside Cli	thy Limite
	r 28a-f show	ctor		gomery	Silver Spri				Yes	
	th with	ral Dire	10e. Street and Number 12907 Allerton La	ane	10f. Zip Code 209		10	og. Citizan of Wi Unite	ed States	
21215-0020	ours efter	Completed by Funeral Director	11. Marifal Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedenf Evar in the Armed Forcas? 1. □ Yes 2 □ No if Yes, Give Year or Dates: 1942	If Yes, specify Cu	f Hispenic Origin? (Spe uban, Mexican, Puerto F o <i>Specify:</i>	cify Yes or No- Ricen, etc.)		- American Indian, , White, etc. White	
5-0	72 hours "naturel",	etec	15. Decedent's Ed (Specify only highest gre	ducation	16a. Decedant's Usual Occ	upation e during most of working	100	16b. Kind of Bus	inass/industry	
121	within ene.	mpi	Elamentary/Secondary (0-12)	Collega (1-4or 5+)	life. DO NOT use reti	red)				
	hygie ner ti	S	AR Falls As Many (First As	+4	Pupil Pe	rsonnel Wo			mery Scho	ols_
Maryland	s 1 and 2 should be filed within 72 hr if Health and Mental Hygiene. It frem 27 is marked other than 'natur other traumatic svent, the Medical	To Be	17. Father's Name (First, Middle, Last) Ernesto Fioramont			18. Mother's Name Annunzia)	
lar	and le me		19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •	19b. Mailing Addrass (Stre	et end Number or Rure	i Route Number,	City or Town, S	tete, Zip Code)	
	Health Feelth France		Marjorie A. Fiora			erton Lane	, Silve	Spring	, MD 209	04
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Domougi from State	Place of Disposition (Neme of camerery, cremetory or other p		Date 2 /19/98		city or Town, Stata	
Balt	permit. Pege Department of Important: If any injury or once.		21. Signature of Fungral Service Licer		22 Arme and Add		al Home			hire
	Physician		23a. Pa/1. Entar fha disease or com strock, or heart failure. List only	plications that caused the dea	ith. Do not enfer tha mode of d	ying, such as cardiac of	r raspiratory arre	20904 ost,	Approximate Interval Baty Onset and D	0
	Examiner		Immediate Cause (Final disaase or condition resulting in death)	· Myo	ARDIAL I	NFARC.	TION		4 DF	275
		ě		Dua to (or as a consequanca of):				924	110
	d d ansit	Examiner	Sequentially list conditions	b. CARI	or as a consequence of):	SHOC			2 DA	1XC
68760,	ertificate be executed ing physician and e as the burial-transit	cal Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· RE	NAL PAL	LURE				
×	death certificate be executed e ettending physiclan and of for use as the burial-transit	Medical	resulting in death) Last		or as a consequence of): ABETES	MELLIT	US			
. Bo	death ce e ettendi ed for use	Physician	Part II. Other significant conditions or	onfributing to death but not re-	sulting In the undartying ceusa	niven in Part I.	23b. Did to	bacco use cont	ribute to the cause o	of death1
P.0	ires that the de signed by the d be deteched			·	, , , , , , , , , , , , , , , , , , , ,					Unknow
Records,	sw requisite sections of the section of the s	Completed by					24a. Was ar perform		24b. Ware autopsy fi available prior to completion of ca of death?	0
æ	The ste h	Con					1□ Ye	s 2 No	1 🗆 Yas 2 🗆	No
Vital	sician: The certificate irector, pag	Be	25. Was casa referred to madical axaminer?			26. Placa of Death	(Check only one	9)		
of V	2 00	0	1 Yas 2 No	Hospital: 1 Inpatient 2	ER/Outpetient 3□ DOA C	thar: 4□ Nursing Hom	ne 5 🗆 Reside	nca 8 Othar	(Specify)	
	or Attanding Photes of Attacher the Street of Attacher the Innertal in by the funeral		27. Mannar of Death 1 Natural 5 Panding 2 Accident Investigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M 1	ury at 2 ork? Yes 2 No	8d. Dascribe ho	w Injury occurre	d	
Division		Certification:	3 Suicida 6 Could not be datermined	28e. Pleca of Injury - Afth building, etc. (Special	noma, ferm, street, factory, officity)	a 2	8f. Location (Str City or Town		r or Rural Routa Numb	ber,
	To the Hospital within 24 hours e To the Funeral C	edical C	29a. Certifier (Check only one) 1 Certifying Physics Certifying Physics 2 Madical Example (Check only one)	ysician: To the best of my kninar: On the basis of examination and manner stated.	owledga, death occurred at the ation and/or investigation, in my	time, data and placa, a opinion, daeth occurre	nd due to the ca	use(s) and man	nar as stated. Id due to the cause(s	i)
	o the	Me	29b. Signature and title of certifier		29c. Lice	nsa number	29	d. Date signed	(Month, Dey, Year)	
	0		Shormak	cano PHY	SICIAN D	40804	1	53/17/	1998	
			30. Nama and addrass of person who			WAL K.	SHARM	A MD	. , ,	
			10620 GBORG 31. Data filed (Month, Day, Year)	SIA AVE #	: 114 SILVE	RSPRIN		D 209	102.	
	Sta Registr		MAR 20 199	3 Julian Davids	on-Rondell					



State of Maryland / Department of Health and Mental Hygiene

					,	Certi	ficate of	Death		Reg. No.	5	0041
П	Dhuais		1. Decedant's Nama (First, Middla, Las	st)		2			2. Date of Do		Yaer	3. Time of Death
	Physic /Medi		Elaine B. Fal	lconer					03	Dey 06	1998	1:36 a.m
	Exami		4a. Facility Nama (If not institution, give					4b. City, Town, or	Location of Dee			
		- ,	Montgomery Gener	ral Hospit	a1			Olney		Montg	omery	
	Funeral Director		5. Social Security Number 6. Sr 301-26-2976 Usual Rasidance of Decedant	ax 7. Aga □M 2ĬĬF	a (In yrs. last i		If Under 1 Year Months Days	If Undar 24 Hr Hours Mir			9. Birthple Counti Ohio	ace (Stata or Forei try)
	and and		10a. Stata 10b. County		10c. City, To	own or Locat	tion				10	Od. Insida City Limit
	Mary	jo	MD Montgome	erv	Beth	esda						1 X Yes 2 □ N
	28a	20	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	iry?
	3a o	0	4521 East West H	Highway. A	nt 150	13	20814			U. S. A		
020	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	by Funeral Director	11. Marital Stetus 1 Navar Married 2 Marriad 3 Widowed 4 Divorced	12. Was Decedent & Armed Forcas? 1 Yes 2 N If Yas, Giva Yaar or Dates:	Ever in U,S.	13. Wa		Hispenic Origin? (an, Maxican, Pua Specify:	Specify Yas or N no Rican, etc.)	o- 14. Re- Bia	ce - Amarica ick, White, a fy: White	NC.
2	hin 72 ho	Completed	15. Decedent's Ed	ucation	16	Se. Deceden	t's Usuel Occup	petion	arkin a	16b. Kind of B	iusinass/indi	ustry
2	C 9	nple	(Specify only highast grade Elementery/Secondery (0-12)	College (1-4or 5	+)	lifa. DO	NOT use retire	during most of wo	orking			
7	filed within the there than the there than the than the than the than the than the the than the	Con	12			Homema	aker			Own H	.ome	
Maryland	tal H d oth	Be	17. Fathar's Nama (First, Middla, Last)					18. Mothar's Ne	me (First, Middle	, Meiden Sumai	na)	
yla		7	Frederick Tyte					Ada Ei	chler			
lar	VI W W W		19a. Informant's Name/Ralationship (7					end Numbar or F		-		
6	C - 0 -		Rhonda Blake / I	Daughter				Road, C				124
Baltimore,	60 - 40 U		20a. Mathod of Disposition 1 □ Burlel 2 ☒ Cramation 3 □ 4 □ Donation 5 □ Othar (Specify				on (Nama of fory or other pla an Cren		3/6/98	20c. Location Alexand		
Ball	permit. Page Department of important: If is any injury or once.		21. Signatura of Funeral Sarvice Licens	Wagn	er_	22. N A	dvent F 211 Lee	uneral & Highway	Cremati , Falls	Lon Serv Church,	ices VA	22046
			23a. Part1. Enter the disaesa, or comp shock, or heart failure. List only of	olications that causad	tha daath. D	o not antar t	ha moda of dyl	ng, such as cardia	c or respiratory	arrest,		Approximeta interval Between
)	Physician /Medical Examiner	Iner	immediate Ceusa (Final disessa or condition resulting In death)	a. Aca	te Dua to (or as	a conseque	go Cor oco of):	rdial.	Information)	to	/:	30 mins
Box 68760,	deeth certificate be axecuted ettending physician and and for use es the burial-transit	Medical Examiner	Sequantially list conditions, if any, leading to Immadiata cause. Enter Underlying Ceuse (Disaasa or Injury that Initiated avants rasulting In deeth) Last	c	Dua to (or es	a consequal	nce of):					
ŭ	etter I for	Cla	Post II Other classificant and strings									
, P.O.	that the c	y Physician/I	Part II. Other significant conditiona co	intributing to death bu	it not rasuiting) in tha unda	iriying causa gr	van in Part I.		Yee 20 No	3 Prob	the ceuea of deat ably 4 Unkno
Records,	e law requires thet the deeth cer hes been signed by the ettendir ge 2 should be detached for use	Completed by								s an autopsy ormed?	evei	ra autopsy findings ileble prior to npletion of cause laath?
	The ate h	5							10	Yas 2 No	10	Yes 2□ No
<u>=</u>	slan: artific ctor,	Be	25. Was casa rafarred to medical axaminar?					26. Placa of De	eath (Check only	ona)		
on of Vital	To the Hospital or Attending Physician: The is whin 24 burs either death. Within 24 burse il Director: After this certificate he completaly filled in by the funeral director, page	ဥ	P 1 Yas 2 DNo Hospitel: 1 Inpatiant 2 ER/Outpetient 3 DNOA Othar: 4 Nursing Home				1	loma 5 ☐ Rasidence 6 ☐ Other (Spe 28d. Dascribe how Injury occurred)		
DIVISION	tal or Attandlins effector: A ed in by the fu	27. Manner of Death 1 Naturel 2 Accidant 3 Suicide 4 Homicida 28a. Date of Injury (Month, Dey Year) 28b. Tima of Injury M 28b. Injury at Work? 1 Yes 2 No 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Specify)								(Street and Num. iwn, Stete)	ber or Rural	Routa Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	edical	29a. Cartifiar (Check only one) 1 Cartifying Phy 2 Medical Exami	sician: To the best of lner: On the basis of and menner ste	axaminetion e	ge, daeth od and/or invasi	ccurrad at the ti tigation, in my c	me, date end piec opinion, daath occ	e, and dua to tha urred at tha tima	causa(s) and m , data and place,	anner as sta end dua to	ited. tha cause(s)
	Withi To th Comp	X	29b. Signatura and title of certifiar .	4 . 4			29c. Licans	sa number		29d. Deta signe	d (Month, D	Dey, Year)
			M. Wager	dell	- mul)	D	3281	7	Februa	an /	1998
		-	30. Nama and address of person who c	omplated cause of de	eth (Itam 23a	(Type Pri	nt)	3-01	/	, - 01-	10	170
			M. Waired Kh	ay MD.	12016	Cer	N416	Ave.	Mento	a ru	1 2	0002
	Sta	te	31. Deta filed (Month, Day, Year)	32. Ragistra	r's Signetura	0 -0	0			1		1
	Registr		MAR 11 199	8 Julia 1	avidson-	Randel	2.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month Year 2 10 AM **Physician** MARCH 1998 Andrew (nmn) Ferenchick /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nema (If not Institution, give street end number) Examiner Mariner Health of Bel Air Bel Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Days 1**⊠** M 2□ F Months Hours Yrs. Jan. 14, 1917 Pennsylvania Director 198-18-9862 81 Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits d 2 should be filed within 72 hours efter death with the Marylan th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examination that is not fed. 1 ☐ Yes 2 No Director Harford Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2618 Kenwood Drive 21085 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1⊠ Yes 2 □ No If Yes, Giva Yaar or Dates: WWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, Bleck, White, atc. 1 Never Married 20 Married Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) State Police State Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Nema (First, Middle, Lest) Ferenchick Elizabeth John (nmn) (nmn) Gretsky 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Pages 1 and 2 s nent of Health an ant: If item 27 la 2618 Kenwood Drive, Joppa, Maryland 21085 Ann E. Ferenchick/ Wife 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete permit. Pages Department of Important: If it any Injury or o IX Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Highview Memorial Gardens3-19-98 Fallston, Maryland 21. Signature of Funeral Services 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest,

Approximate Approximate **Physician** - Alzheimer: Type Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Yeurs Examiner Due to (or es e consequence of) Physician/Medical Examiner physicien and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, laading to immadiata ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted avents resulting In deeth) Lest Due to (or es a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes 2 No 3 Probably 4 Umknown Coronary Artery Disease à 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Cerebrovascular Disease 24e. Wes an eutopsy Completed certificate has b 1 □ Yes 2 □ No 1 Yes 2 TNo or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? funeral 28d. Describe how Injury occurred 28b. Time of After 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end dua to the cause(s) end menner steted. (Check only one) To the F 29d. Data signed (Month, Dey, Year) 29c. Licansa number March 16, 1998

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4 NDREW FERENCHICK

J. Kevin Lynch MD 31. Dete filed (Month, Bay, Year) State

2 North Ave. 38/ Flaist al Siedawe Randell

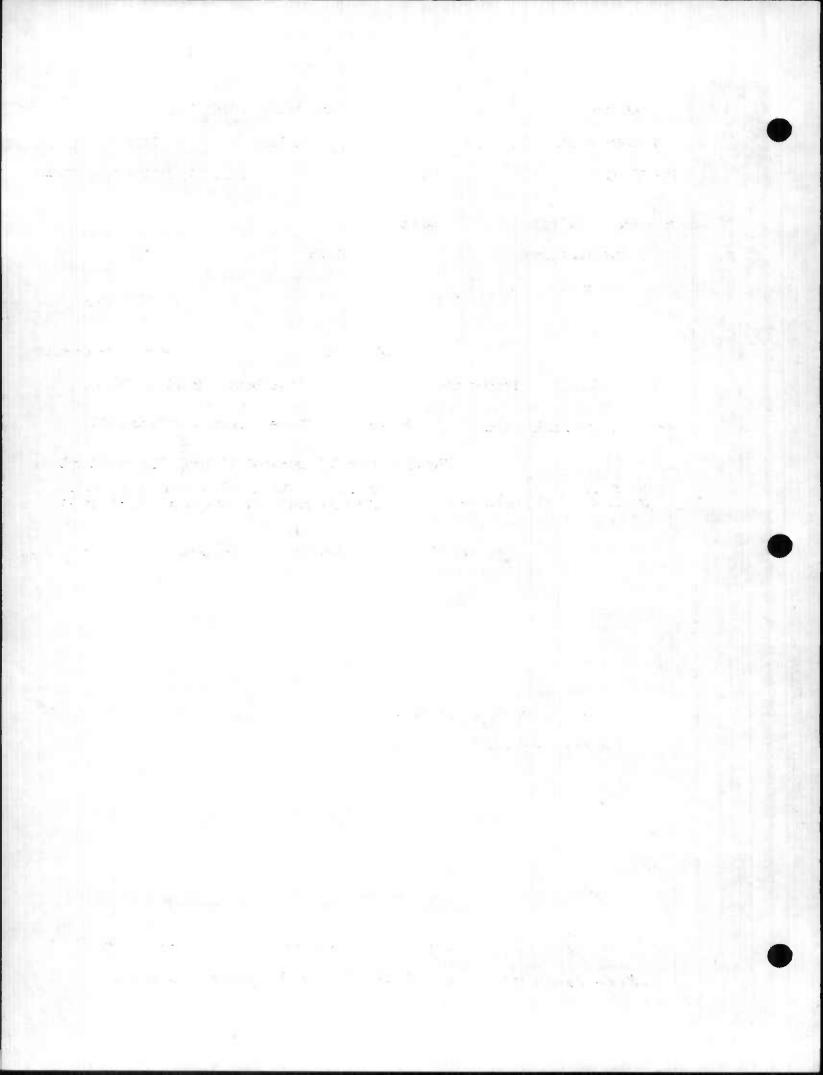
no is

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

D350/2

Bel Air, Md. 21014.

Registrar



			Certificate of	or Death		g. No.					
an	Decedent's Neme (First, Middle, La	st)			2. Dete of Deeth Month		3. Time of Death				
al	Catherine Regir			The same	March 13		10:30 AM				
ier	4e Fecility Neme (If not institution, giv	e street end number)		4b. City, Town, or	Location of Deeth	4c. County o	f Death				
	SHADY GROVE	ADVENTIST HO	SPITAL	ROCKV			GOMERY				
	5. Sociel Security Number 6. 5	Sex 7. Age (In yrs. le	st birthdey) II Under 1 Ye Yrs. Months Da		(Month, Dev.)	Yeer)	Birthplece (State or Foreign Country)				
	5/8-09-90/4	1 M 2LAF 88	115.		Jan. 23,	1910	Washington, DC				
	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City.	Town or Location				10d. Inside City Limits				
5	Manual and Manual						1 XYes 2 No				
Director	Maryland Montgon	dery Ge.	rmantown 10f. Zip Coo	10	100	g. Citizen of Wi	het Country?				
ō	19020 McFarlain I	rive		20879		U.S.A.					
era	11. Marital Status	12. Wes Decedent Ever in U.S			Specify Yes or No-		- American Indian,				
Funerai	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☑No	If Yes, specify (of Hispanic Origin? (S Suban, Mexican, Puer	to Ricen, etc.)		, White, etc.				
by F	3 12 Widowed 4 Divorced	If Yes, Give Yeer or Detes:	1 □ Yes 2 🔀	No Specify:		Specify:	white				
8	15. Decedent's Ed		16e. Decedent's Usuel Oc	ccupetion	11	6b. Kind of Bus					
Completed	(Specify only highest gra	ade completed)	(Give kind of work do life. DO NOT use re	one during most of wo tired)	rking						
5	Elementery/Secondary (0-12)	College (1-4or 5+)	housewife			own	home				
De C	17. Fether's Neme (First, Middle, Last,)		18. Mother's Na	me (First, Middle, Me	eiden Surneme)				
0	Edward Scan	lon		Bric	lget Delan	iev					
•	19a. Informent's Neme/Reletionship (19b. Meiling Address (Str		~		Stete, Zip Code)				
	Kathleen A. Fitz	erald/daughter	19020 McFa	rlain Dr.	Germanto	wn. Md.	20879				
	20e. Method of Disposition	20b. Ple	ce of Disposition (Neme o	1			City or Town, Stete				
	1 Buriai 2 □ Cremetion 3 □	JRemovel from State	metery, cremetory or other		fan 10 00	C41	Condes Md				
	4 □ Donetion 5 □ Other (Specification 1) Other (Specification 2) Other (Specification 2)		e of Heaven		dar.10,90	Silver	Spring, Ma.				
	21. Still the trolleral Service Lices	1500	DeVol Fu	neral Home							
	Junge	·VVau		consin Ave							
	23a. Pert1. En er the disee e, or com shock, or heart ailure. List only	plications that caused the death. one cause on each line.	Do not enter the mode of	dying, such es cerdie	c or respiretory erres	st,	Approximete tntervel Between Onset end Deeth				
							Chiset and Death				
	Immediate Cause (Final disease or condition resulting in death)	e cardiopulmon	ary arrest				minutes				
		Due to (or	es e consequence of):								
Examiner		b. sepsis					5 days				
	Sequentially list conditions, if env. leeding to immediate	Due to (or	es e consequence of):								
	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	c pneumonia					5 days				
	thet initieted events resulting in death) Last	Due to (or	es e consequence of):								
by Physician/Med	L	decubitus ul	cers				2 weeks				
3											
20	Pert II. Other significant conditions of	contributing to death but not result	ting in the underlying ceuse	e given in Pert I.	23b. Did tob	acco use con	tributa to the cause of death?				
	urinary tract in	fection, acute	sinusitis		1 🗆 Ye	2X No	3 Probably 4 Unknown				
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State Registrar

30. Name and address of person who completed cause of death (ttern 23e) (Type, Print)

Jatinder S. Sekhon, M.D., 501 N. Frederick Ave., #102, Gaithersburg, Md. 20877 31. Dete filed (Month, Dey, Year)
MAR 18 1998

32, Registrer's Signeture Wa Davidson

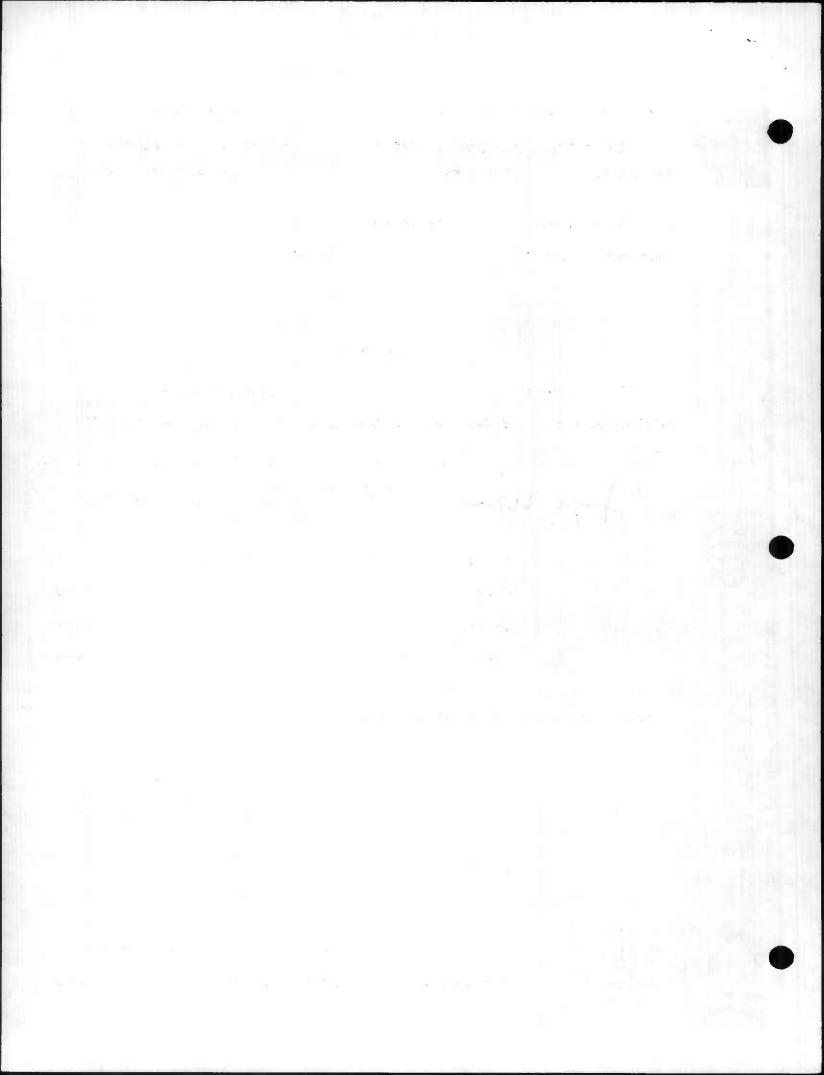
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March 14,1998

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dafa of Death **Physician** LOSTER ORO THY 18, 1998 MARCH /Medical 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sax 8. Date of Birth (Month, Day, Year) Birthplece (State or Foraign Country) **Funeral** 1□M 2ӁF Yrs. Director 68 577-38-5985 June 3, 1929 Connecticut Usual Rasidance of Decedent the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Modical Exeminer must be notified as 1 Yes 2 No Director Hyattsville Maryland Prince George's 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5609 36th Avenue U.S.A. 20781 Funeral 12. Was Dacedanf Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ੴ No If Yas, Giva Yeer or Detes: Was Decedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 72 hours efter 1 ☐ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7 Department of Heelth end Mental Hygiene. Important: if tem 27 is marked other than "n any injury or other traumatic event, an Heal app folges. Prince George's County Eiamantary/Secondery (0-12) College (1-4or 5+) 5+ Audio-Visual Specialist Board of Education 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Frank Unwin Viola Byrnes 19a. tnformant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 5609 36th Avenue, Hyattsville, Maryland Harold W. Foster - Husband 20781 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Fort Lincoln Cemetery 3/23/98 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enfer tha . ser sa, or complications that caused the deeth. Do not antar tha moda of dying, such es cerdiac or raspiratory arrast, shock, or haart failure. List only ona causa on aach lina. Approximeta Infarvel Batwean **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in daath) DAY Examiner Dua to (or as e consequanca of): buriel-trensit The lew requires that the death certificete be executed Sequantially list conditions, if any, leading to immadiata ceusa. Enter Undarlying Ceusa (Disaasa or Injury that initiated avents rasulting in daath) Last end Dua to (or as a consequence of) Box 68760. physiclan Physician/Medical the Dua to (or as a consequance of) 98 ettending | P.O. 1 signed by the e Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown Records, þ 24b. Ware autopsy findings available prior fo completion of cause of death? Completed 24a. Was an autopsy performed? page 2 : 1 ☐ Yas 2 No 1 TYas 2 TNo certificate Division of Vital I or Attending Physician: effer death. 25. Was cesa raferred to medicel Be 26. Pleca of Death (Check only one) Hospital: 1 Spinpatient 2 EN/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) To 1 Yas 2 No this 28a. Date of Injury (Month, Day Year) 27. Mannar of Deeth 28c. Injury at Work? 28b. Time of Certification: 28d. Dascribe how injury occurred After 5 Panding investigation 1 Natural s efter death.

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2 Madicat Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred et the time, dete end plece, and due to the causa(s) and menner stafed. Medical 29a. Certifier (Check only 29b. Signature englitla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 045660 30. Nama and addrass of person 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State Registrar

DHMH 16 Rav 6/95

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	21. Signature of Funeral Serv			F				ress of Facil		0/1//90)	BRENTV	, עטטיי	MAR	ILAND
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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10a. State 10b. County		10c. City, Town						10d. Inside	City Limits
MD Montgo	mery	Ro	ckville					1 🕸 Y	es 2 No
10e. Sfreet end Number			10f. Zip Co			10	g. Citizen of V		
810 Westmore	Avenue			20850			U.S	.A.	
11, Marital Sfatus	12. Was Decedent E	ver In U,S.	13. Was Decedent	f of Hispanic Or	rigin? (Spe	ecify Yes or No-		e - American Indian	
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No	0	1 Yes 2X	Cuban, Mexica		nicen, etc./		k, White, etc. Black	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dales:		TLI Yes Za	No Specify.	•		Specify	Diack	
15. Decedent's Edu (Specify only highest grad		16a.	Decedent's Usuai O	ecupation fone during mos	st of work	ing 1	6b. Kind of Bu	isiness/industry	
Elementary/Secondary (0-12)	College (1-4or 5-	+)	(Give kind of work of life. DO NOT use r	etired)			T www.	scape	
		1	Laborer	145.11	- 2-61	- APT - A A A A A A A A A A A A A A A A A A			
17. Fether's Neme (First, Middle, Last)	nor					e (First, Middle, M aska Co		18)	
Frizzel Gard									
19a. Informent's Name/Reletionship (7)			. Mailing Address (S 10 Westm)
Catherine John	son (Aun				e.,				
20a. Method of Disposition 1 Derivation 2 □ Cremation 3 □ F	Removal from Stefe	cemeter	Disposition (Neme ry, cremetory or othe	r plece)	, b			ille, MI	
4 ☐ Donation 5 ☐ Other (Specify)		St. I	Mary's C			/19/90	ROCK V.	Tite, M	
21. Signature of Funeral Service Licens	100	1	22. Name and A			HOME,	D 7\		
1-400ga1(4	mour	dell	ROCKVI			20850	r • W •		
23a. Part . Enter the disease, or comb	lications that caused t			TILL A IN	י עני	20030			
SHOUR, OF HERRITANIUM. LIST ONLY O	ne cause on each line	the deefh. Do r e.					st,	Approxir Interval	Between
shock, or heart fallure. List only o	ne cause on each line	the deeth. Do r e.					st,	Intervai	
Immediate Cause (Final disease or condition	ne cause on each line	θ.	not enter the mode o	f dying, such as	s cardiac		st,	Intervai	Between
	a. STAVS	0. 600 MD	not enter the mode o	f dying, such as	s cardiac		st,	Intervai	Between
Immediate Cause (Final disease or condition	a. STAVS	0. 600 MD	ote A	f dying, such as	s cardiac		st,	Intervai	Between
Immediate Cause (Final disease or condition resulting in death)	aSTAVS C	e. OUND Oue to (or as a o	ote A	f dying, such as	s cardiac		st,	Intervai	Between
Immediate Cause (Final disease or condition resulting in death)	aSTAVS C	e. OUND Oue to (or as a o	ontenter the mode of the consequence of):	f dying, such as	s cardiac		st,	Intervai	Between
Immediate Cause (Final disease or condition resulting in death)	a. STAVS C	Due to (or es a	ontenter the mode of the consequence of):	f dying, such as	s cardiac		st,	Intervai	Between
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	a. STAVS C	Due to (or es a	consequence of):	f dying, such as	s cardiac		st,	Intervai	Between
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State Registrar

MARIA GIO GALLANDA SALANDA SAL MAR 19 1998

29b. Signature and fittle of certifier

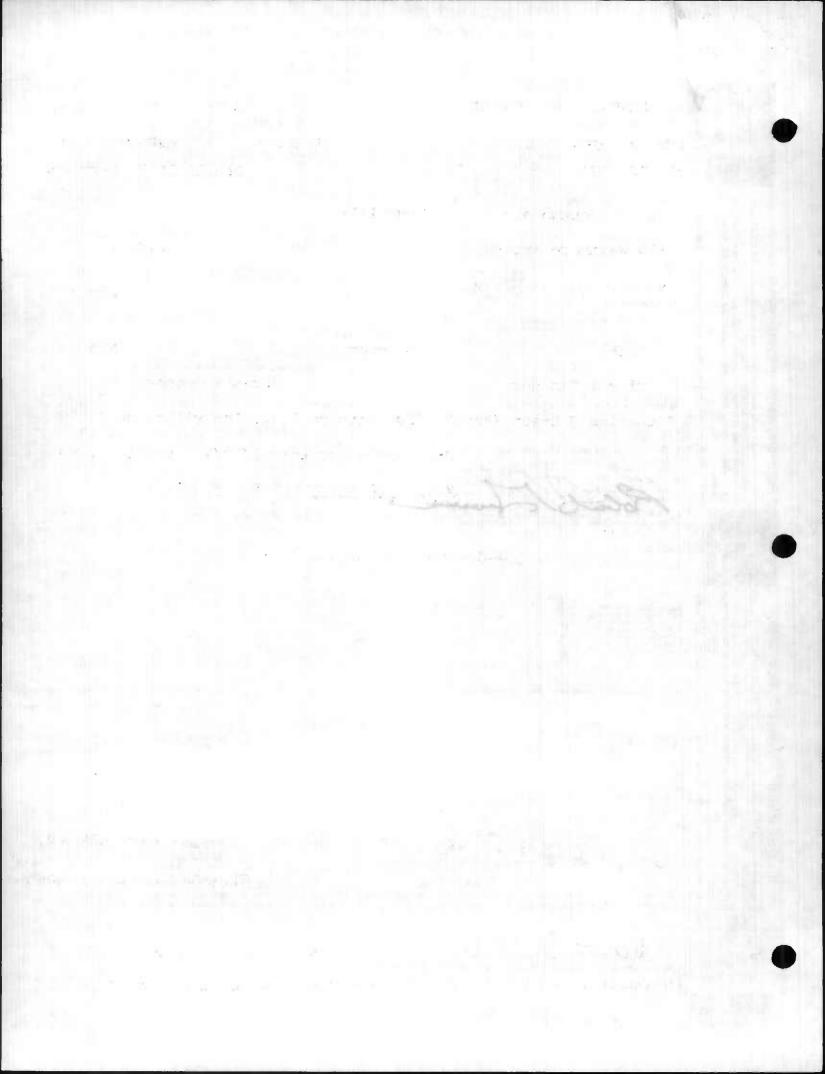
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIAN A. WORSTON 111 Pe 111 Penn Street, Baltimore, Maryland 21201

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year)

MARCH 16, 1998



7. Age (In yrs. last birthday)

BROOKLYN

Yrs.

10c. City, Town or Location

69

12. Was Decedant Evar in U,S. Armed Forces?

1 ☐ Yes 2 1 No If Yas, Give Year or Dates:

Coilege (1-4or 5+)

(SON)

1□M 2₩F

State of Maryland / Department of Health and Mental Hygiene ()

10f. Zip Code

11236

HOMEMAKER

1 ☐ Yes 2 ▼ No Specity:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1998 MARCH 12, 10:30 AM GOLDSMITH 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY

BETHESDA

13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 26, 1928

18. Mother's Name (First, Middle, Maiden Sumame)

ROSE ROSENCROWN

3114 SW HAMPSHIRE ST. - PORTLAND, OREGON 97201

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Birthplaca (Stata or Foreign NEW YORK

10g. Citizen of What Country?

UNITED STATES

16b. Kind ot Business/Industry

14. Race - Amarican indian, Black, Whita, etc.

OWN HOME

Specify: WHITE

10d. Inside City Limita

1X Yes 2 □ No

Physician /Medicai **Examiner**

JANET

5. Social Security Number

101-20-5150

NEW YORK

10e. Street and Number

10a. State

Usual Residence of Decedent

105-20 AVENUE L

1 Navar Married 2 Married

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondery (0-12)

17. Father's Name (First, Middle, Last)

19a. informant's Neme/Relationship (Type, Print)

JOEL GOLDSMITH

JOSEPH LISS

10b. County

KINGS

15. Decedent's Education (Specify only highest grade completed)

Funeral

Director the Maryland

Director

Funeral

by

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at permit. Peges 1 and 2 should be filled within 72 hours after d
Department of Heelth and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Examples.

Baltimore, Maryland 21215-0020

Physiclan /Medical Examiner

Physician/Medical þ Completed Medical Certification: To To the Funeral

Division of Vital Records, P.O. Box 68760,

roldSmilh,

	Removal from State	cametery, cremetor	y or other	piaca)			
4 ☐ Donation 5 ☐ Other (Specify,		BETH DAVID	CEME	TERY	3/15/98	ELMONT,	NEW YORK
1. Signature of Funeral Service Licans	ea /	DANZ	LANSK	ddress of Facility Y-GOLDBER(
3a. Part1. Enter the disease, or comp	lications that says and the						MARYLAND 2085
shock, or heart failura. List only o	ne cause on each line.	death. Do not antar the	i moda of	dying, such as cardia	ic or respiratory a	arrest,	Approximate Interval Between Onset and Death
nmediate Cause (Final isease or condition asulting in death)	CARD	IORETP.	IRA	770RX	ARK	REST	IMMEDI
	Due 1	to (or as a consequence	a ot):	(1)	KMDH	MA	ZMAC
equentially list conditions, any, leading to immediate	b. / / O / O - Due	to (or es a consequenc	a of):	1 1	7-17-71	0//	3 1103
Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Diseese or Injury that initiated events	с.		G - A3				
esulting in death) Last	Due	to (or as a consequence	3 Ot):				
	d						1
art II. Other significant conditions co	ntributing to death but no	at resulting in the underly	ring cause	given in Part I.	23b. Did	tobacco use co	ntribute to the cause of deat
					10	Yes 2 No	3 Probably 4 Unkno
					24a. Was	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
					X	Yes 2□No	1 □ Yas 2 No
				26. Place of De	eath (Chack only	one)	
examiner? \	Hospital:	2 ☐ ER/Outpatient 3	□ DOA				er (Specify)
examiner? 1 Yes 2 2 No 7. Menner of Ceath 1 Natural 5 Pending 2 Accident Investigation	Hospital: 1 🏻 inpatient 28a. Date of Injury (Month, Day Ye		28c.	26. Place of De Other: 4 Nursing Injury at Work? 1 Yes 2 No	Homa 5 ☐ Ras		
examiner? 1	28a. Date of Injury (Month, Dey Ye	28b. Time of Injury M	28c. I	Other: 4 Nursing	Homa 5 Rasi 28d. Describe	idenca 6 □Oth how Injury occur	
examiner? 1 Yes 2 No 7. Menner of Oeath 1 Natural 5 Pending Investigation 3 Suicida 6 Could not be determined 9e. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Dey Ye 28e. Place of Injury building, etc. (S	28b. Time of Injury N At home, tarm, street, to pecify) y knowledge, death occumination and/or investignments.	28c. I	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Homa 5 Rasi 28d Describe 28t Location City or To	idenca 6 Oth how injury occur (Street and Numb wm, Stete)	red ber or Rural Route Number,
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State Registrar

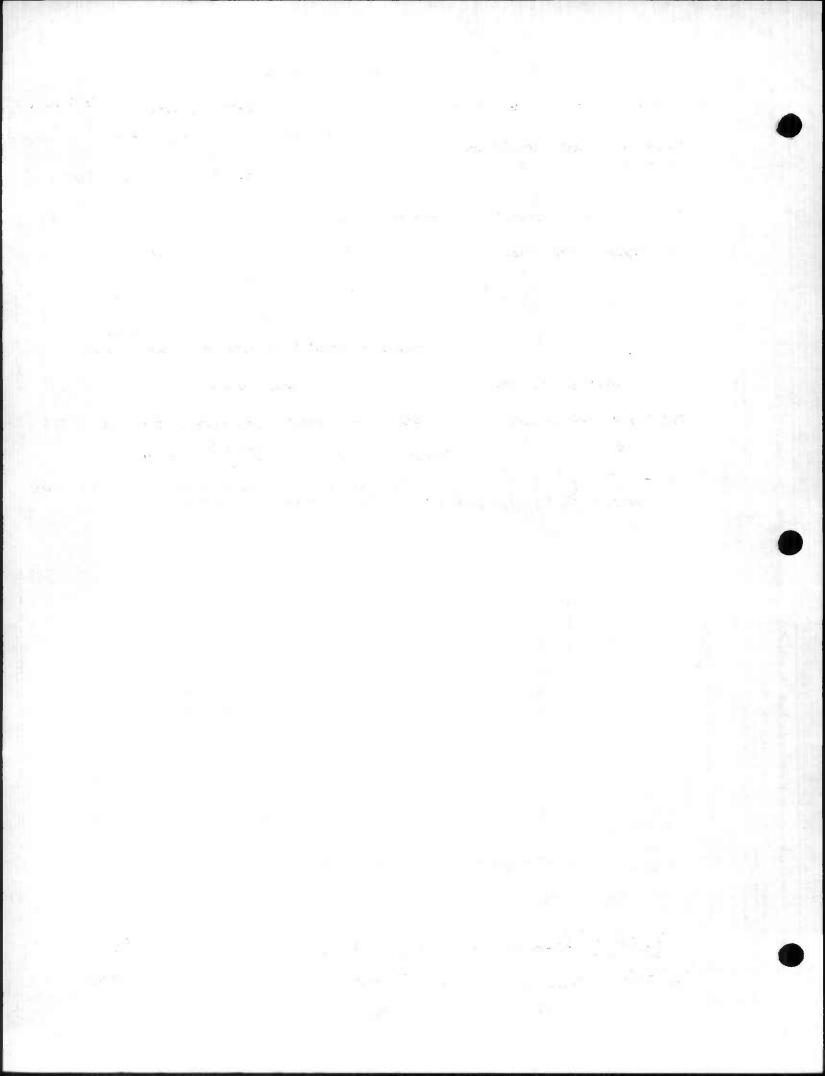
within 24

Toler C. Frence

State of Maryland / Department of Health and Mental Hygiene

					,	Ce	rtificate d	of Death		Reg. No.	3 1	001	18
		7	1. Decedent's Neme (First, Middla, Les	st)					2. Dete of De	eth	Vana	3. Tima o	
	Physici /Medic		Evelyn Marie	Grumb	ine				Month	4, 1998	Yeer	7:45	$p \cdot m$.
1	Examir		4e. Facility Nama (If not Institution, give	street and number)				4b. City, Town, or I			of Deeth		
			Chesapeake Health	care Cent	er			Arnold		Anne A	rund	lel	
	Funeral Director		5. Sociel Security Number 6. Sec			st birthdey) Yrs.	If Under 1 Ya Months De		8. Date of Bir (Month, De Nov 19,			piace (State ontry) yland	or Foreign
	p ,		Usuel Residence of Decedent		10. 02.	Town and							
	show	7.	10a. Stata 10b. County MD Anne	Arundel	TUC. City	Town or Lo	na Park				1	10d. Insida C	ity Limits 2⊠ No
	Ne M	ecto	10e. Street end Number	Ardider		Sever							243110
	23a or	Funeral Director	260 Cypress Cree	k Road			10f. Zip Cod			10g. Citizen of V USA		ntry?	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Marital Examines must be notified at ORCE.	by	11. Meritei Stetus 1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Wss Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Yeer or Detes:			Was Decedent of Yas, specify C	of Hispenic Origin? (Stuben, Mexicen, Puert No Specify:	pecify Yes or No o Rican, etc.)	14. Reco	k, White,	cen Indien, etc. nite	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Usuel Oc	cupation ne during most of wor tired)	rkina	16b. Kind of Bu			
2	ithin	nple	Elementery/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use re	chool Food	Commission	Food			
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7	Mer Merke Merke	70						Anna	Unknow				
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ė,	Healt Fm 2		20a. Method of Disposition	agniter	20b. Pie	aca of Dispo	osition (Name of	s Creek Ro	Deta Sev	20c. Location -			146
altimore,	Pages ment of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		Ce	matery, crei	metory or other Cremato	plece)	March 9 1998	Baltim			
Ball	permit. Depart Import any Inj		21. Signature of Puneral Service Model	1/1/	~~) B	arranco	dress of Fecility & Sons, P	.A. Seve	erna Par	k Fu	neral	Home
		4	23a Pant Enlar the diseese, or com- lock, or heert feilure. List only	thet caused	the death.	Do not en	95 GOV.	Ritchie H	wy., Ser	verna Pa mest.	rk,	MD 21 Approxime	146
	Physician		rock or heart feilure. List only	on each lin	Θ.				,		1	Intervel Bel Onset and	tween
	/Medical	1	Immediate Cause (Final disease or condition	A1	tzhe	imers					1	v	ears
	Examiner	(resulting in death)	0	Due to (or	es e conse	quence of):				- 1	,	ears
_	D #	Jon J			(, , , , , , , , , , , , , , , , , , , ,				1		
,	ificate be executed g physician and es the burial-trensit	edical Examin	Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or injury	p	Due to (or	es e consec	quence of):				i		
68760,	ysicla bur	cal	thet initieted events	c	Due to (or	es e consec	uance of):				-		
89 x	+ 0.4	~	resulting In death) Last	d	,		,				<u> </u>		
Box	etter for u	Physician/	Dad II Other standings and sea state.						1				
o.	the d yy the achec	hysi	Pert ii. Other significant conditions co	intributing to death bu	t not resul	ting in the u	inderlying cause	given in Pert I.		tobacco use cor			
o.	s thet	by P	Breast Cancer						'''	100 26110	3 1 10	Deloity 4	Officiowii
Records,	e lew requires thet the deeth cei hes been signed by the ettendir ge 2 should be deteched for use	Completed t	Hypertension							en eutopsy ormed?	8V	ere autopsy allable prior empletion of deeth?	to
-	The ate h	Con							10	Yes 2 No	1[□Yas 2□	No
<u>E</u>	ystcian: This certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dee	oth (Check only	one)			
of Vital	Physician: rthis certific rral director,	2	1 Yes 2 No	Hospitel: 1 Inpatier	nt 2 🗆 E	R/Outpetier	IL SLI DOA		lome 5 🗆 Resi	dence 6 Oth	er (Specif	(y)	
Ç	the une	tlon:	27. Mennar of Deeth 1 ☑Neturel 5 ☐ Pending invastigation	28e. Dete of Injury (Month, Dey	Year)	28b. Tima o Injury		njuryat Work? □ Yas 2 □ No	28d. Describe	how injury occurr	red		
Division	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident invastigation 3 Sulcide 6 Could not be 4 Homicide determined	28a. Placa of Injubulding, etc.	ry - At hon . (Specify)	ne, ferm, st			28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	si Route Num	nber,
	To the Hospital within 24 hours a To the Funeral E completely filled	edical	29e. Certifier 1 ☐ Certifying Phy (Check only eng) 2 ☐ Medical Exam	sicien: To the best of iner: On the basis of end manner stat	examinetic	ledge, deetl on end/ <i>o</i> r in	h occurred et the vestigetion, in m	time, dete end piece y opinion, deeth occu	, snd due to the rred st the time,	ceuse(s) end me dete and pieca,	nner es s and due to	teted. the cause(B)
	within 2 To the comple	Ž.	29b. Signature and title of certifier				29c. Lic	ense number		29d. Dete signed	(Month,	Dey, Year)	
	- > - 0		1 Doll	PE		MC	N	11.964		2/	110	5	
		1	30. Name and eddress of person who o	ompleted cause of de	eth (Item	23a) (Type	Print)<	10 (- 1	A	> / (2 (0	
			31. Date filed (Month, Day, Year)	conus	150	9 10	2. tel	- He	XA	rus()	1 6	el 2	1012
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** -1 LLIAN 12.15AM GINAITIS MARCH 1998 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not Institution, give street end number) Examiner BALTIMORE HOSPITAL CENTER HARBOR If Under 24 Hrs 5. Sociei Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F Months Hours 217-09-1263 Director 78 APR. 5, 1919 MARYLAND Usuei Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinet must be notified at 1 Yes 2 No Director MARYLAND BALTIMORE BALTIMORE HIGHLANDS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2730 ARBUTUS AVENUE 21227 U.S.A. Funeral 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bieck, White, etc. 2 should be filled within 72 hours efter n and Mentel Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: ò WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 0 MACHINE OPERATOR BOTTLING COMPANY 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be SAMUEL MELVIN HOWARD MARIE CHENOWETH 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Heelth and Important: If item 27 is m any Injury or other treum 2730 ARBUTUS AVENUE, MARY LOU LEE (DAUGHTER) BALTIMORE HIGHLANDS, MD 21227 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BELTSVILLE, MARYLAND CHESAPEAKE CREMATORY 3/6/98 21. Signature of Foreral Selvice Licensee 22. Neme and Address of Facility SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 the monifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximete interval Between Onset and Death 23a. Pert1. Enter the shock, or hear **Physician** Immediate Cause Final disease or condition resulting in death) /Medical & EXACERBATION OF CHRONIC OBSTRUCTIVE **Examiner** Due to (or as a consequenca of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE ician end buriel-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last Due to (or as a consequence of): physician s the burie Box 68760. Physician/Medical Due to (or es e consequenca of) 23b. Did tobacco use contribute to the ceuse of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24b. Were autopsy findings eveilable prior to 24e. Was en autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No Be 26. Plece of Death (Check only one)

25. Was case rafarred to medical exeminer? 1 Yes 2 No Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of injury

27. Menner of Death 1 DNatural 2 Accident 3 Sulcide

2

Certification:

Medical

funeral

death.

aftar death.

24 hours a

To the Vithin 2

28a. Date of Injury (Month, Dey Year) 5 Pending investigation

1 29npatient

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

6 Could not be determined 4 Homicide

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signaturg

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

MD

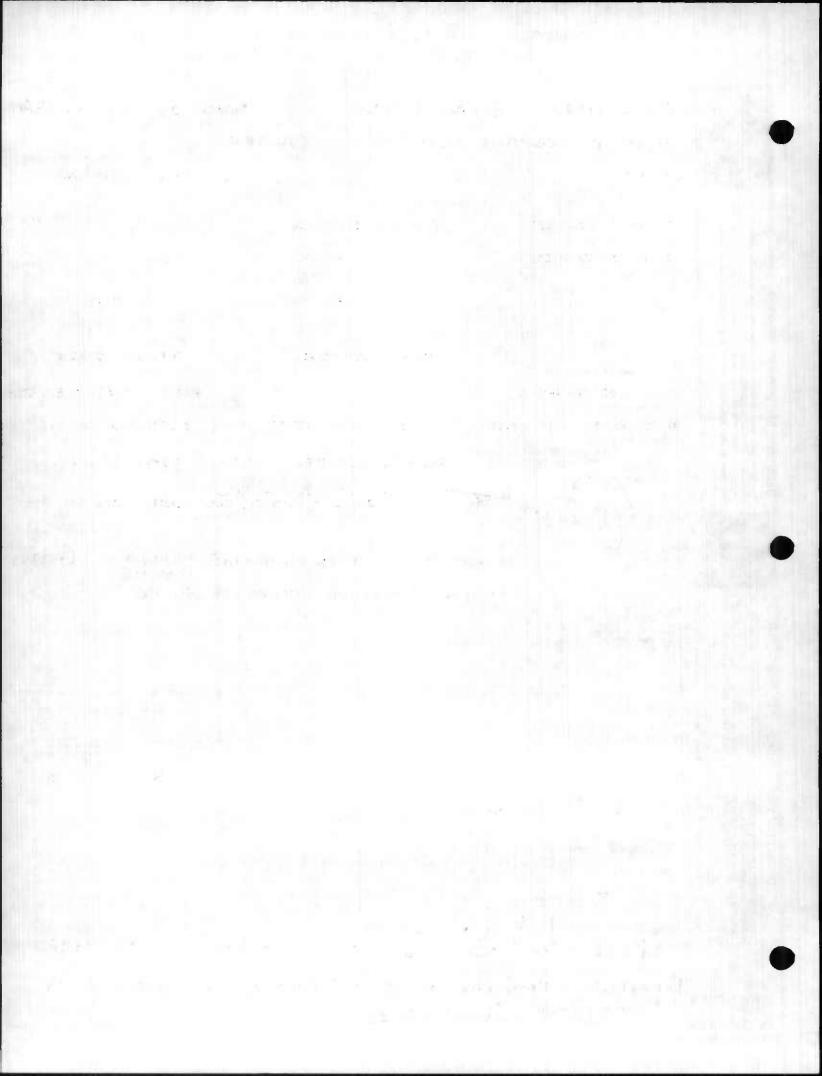
AS244161422 MARCH OS,

Name and address of person who completed cause of deeth (item 23e) (Type, Print)

RATNAKARAM, 3001 S. HANDYER ST. BALTIMORE 21225 RAMAKRISHWA 31. Date filed (Month, Day, Year)

State Registrar

32 Registrar's Signeture raia Savidson Randall MAR 1 0 1998



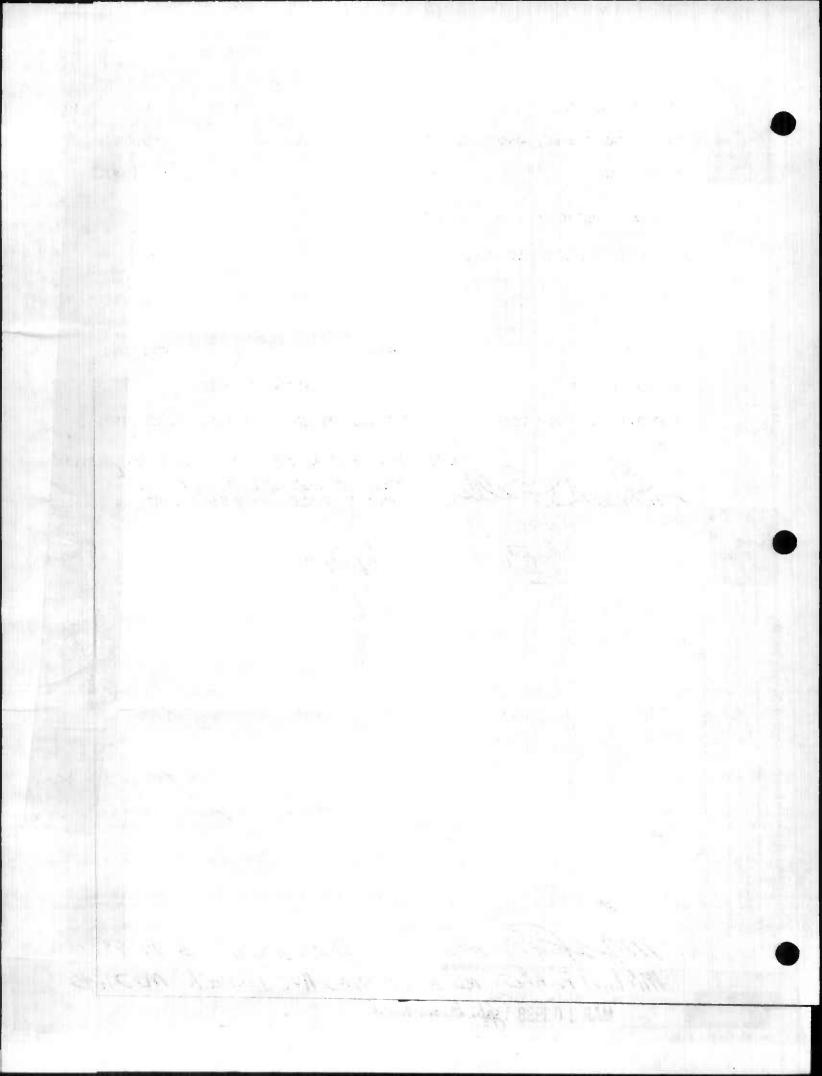
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Name (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month FLORENCE G. GRAY 1998 MARCH 18 3:10AM /Medical 4e. Facility Name (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 CRUSADER ROAD, APARTMENT 101 CAMBRIDGE DORCHESTER 5. Social Sacurity Number If Under 1 Yaar If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, **Funeral** 9. Birthplaca (Stata or Foreign Country) MARYLAND 1□ M 2 KF Days Director 92 Yrs. 218-24-7467 Usual Residence of Decedent the Maryland il Hygiene. other than "neturel", or items 23a or 28a-f show went, the Madical Exerciper must be notified at 10a. Stata 10h County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND DORCHESTER CAMBRIDGE 1 XYas 2 □ No 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? death with 21613 USA 312 CRUSADER ROAD, APARTMENT 101 Funeral 12. Wes Dacadant Evar In U,S. Armed Forces? 1 Yes 2 XNo Was Decedant of Hispenic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Reca - Amarican Indian, Black, Whita, atc. filled within 72 hours efter 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highast grada completed) 16e. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 ahould be fred. Department of Health and Mental Hyg Important: If them 27 is marked other any Injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Meidan Sumame) Be ALEXANDER GRAY BETHANIA SMITH 19a. Informant's Name/Ralationship (Typa, Print) 19b. Meiling Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Coda) BEATRICE GRAY/DAUGHTER 102 PRINCETON AVENUE, SALISBURY, MD 21801 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛱 Burial 2 □ Cremation 3 □ Removal from State DORCHESTER MEMORIAL PARK 3/20/98 CAMBRIDGE, MARYLAND 4 Donation -trj□Other (Specify 22 Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET, MD 21631 Entar the diseesa, or m, lic tilns mat caused the daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, to haart failura. List niy in cause on aach lina. Approximate Interval Betwaan Onset and Death Physician /Medical mediate Cause (Final mur disease or condition resulting in death) Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last for use as the buned tran Dua to (or as a consequanca of): The lew requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of desth? signed by 1 Yes 25 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate hes 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 No Attending Physician: Be 25. Wes casa rafarred to medical 26. Place of Deeth (Check only ona) exeminer' Othar: 4 Nursing Homa 5 Aesidanca 6 Othar (Specify) Certification: To 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27 Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Floute Number, City or Town, State) filled in by 4 Homicide ò To the Hospital o within 24 hours af To the Funeral Di 29a. Certifian 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) end menner as stated.

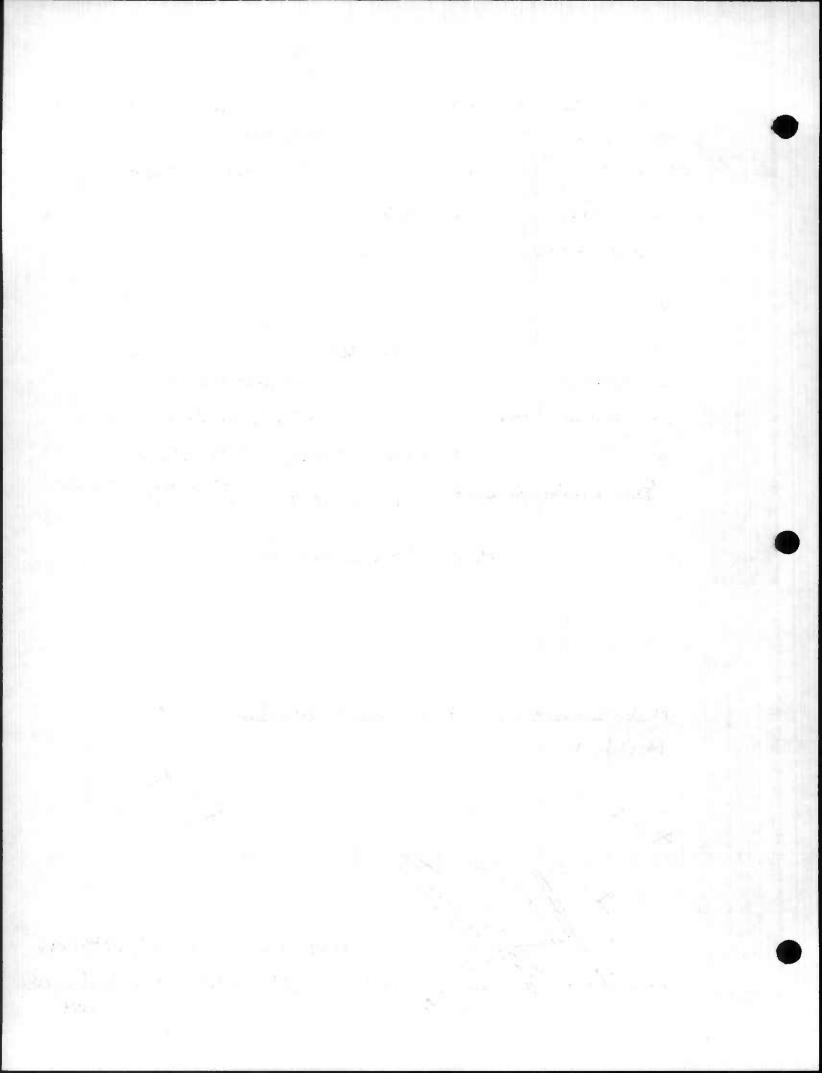
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. Medical (Check only onel 29d. Data signed (Month, Day, Year) 29b. Signetura and titla of certifier 29c. License number des 30. Nama and sources of person who completed cause of death (Itam 23a) (Type, Print)

Michael Factor MD 30 2 Col 302001/125 AVE HUN/OCK MOD1643 32 Baylars Stangture Kardall 31. Date filed (Month, Day, Yaar) MAR 2 0 1998

Registrar

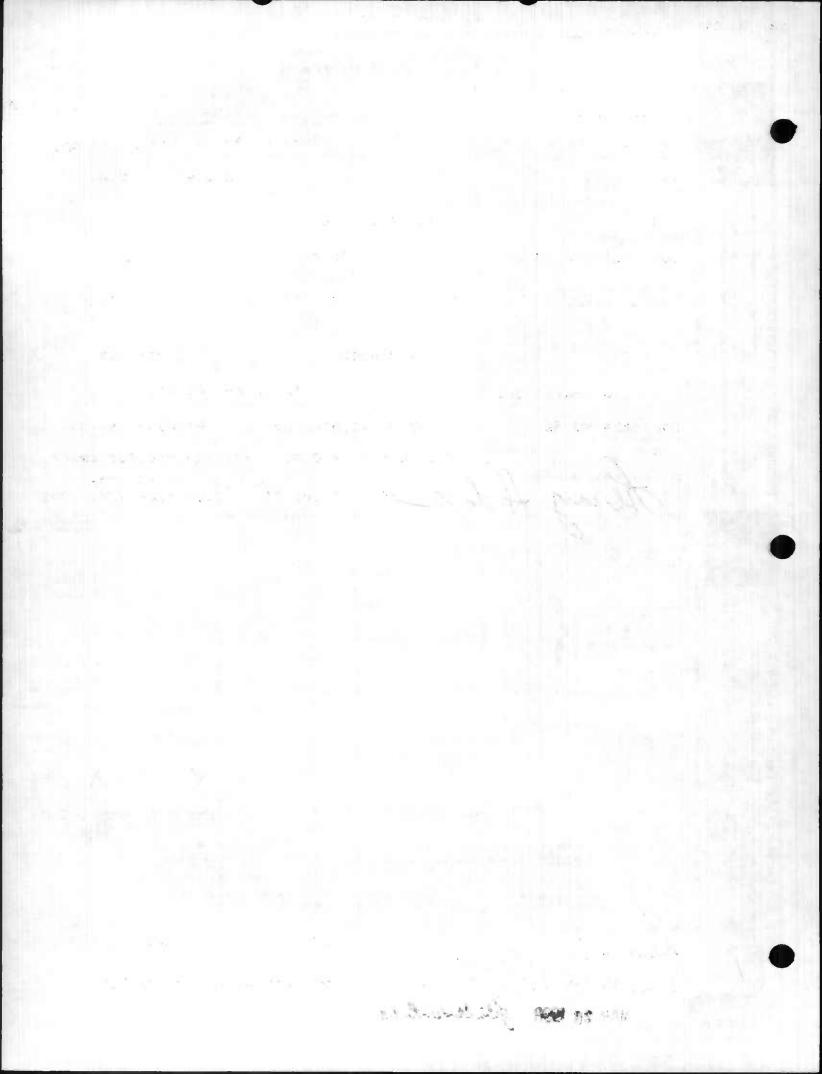


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020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28=-f show any injury or other traumatic event, the Mod cal Examiner must be notified at once.	by	11. Maritai Status 1 ☐ Navar Married 2 ☐ 3 ☑ Widowad 4 ☐ Divo		12. Was Dace Armed For 1 Tas If Yas, Giv Yaar or Da	2 XNo	II	Vas Dacadant of Yas, specify Cub	Hispanic Origin? (Span, Maxicen, Puart	pecify Yas or No o Ricen, atc.)		k, Whita		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Alexander Green March 16, 1998 /Medical 6:00pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. 9. Birthplaca (State or Foreign Country) Carolina 5. Social Security Number 8. Date of Birth Month Day Year May 12, 1908 7. Age (In yrs. last birthday) 1**XX**M 2□ F 579-10-7783 89 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Crownsville Mary land Anne Arundel ¥X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1255 Bacon Ridge Road 21032 U.S.A. Completed by Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married **Black** 1 Yes 2XXNo Specify: 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Mail Handler Washington Terminal 3rd Grade 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Viola Johnson John Green, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Bertha M. Hudson (Daughter) 3530 Edwards Street Springdale, Maryland 20774 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/21/98 Landover, Maryland Harmony Memorial Park 21. Signature of Funeral Service Licenses 22 Name and Address of Facility ROITINS Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the discusse of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. Let only one cause on each line. Approximate interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in deeth) 3 weeks freumoma Due to (or es e consequenca of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequenca ot) Physician/Medical Due to (or as a consequenca of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Hemorrhyic cerebral interation 1 Yes 2 No 3 Probably 4 Onknown þ Be Completed 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performad? Atral Thrombus 25. Was case referred to medical examinar? 1 ☐ Yes 2 ☑ No 26. Plece of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred

Attending Physician: The law requires that the death certificate be executed and the buriel-tran P.O. Box 68760, ettending physician for use as the burie cate hes been signed by t page 2 should be detech Division of Vital Records, After this certificate hes spital or Attanding Physhours efter death.
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Examiner

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28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 3/17/18 125079 Durid

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Don H. Yablanowite, no 7404 Executive P1. H502, Jewish

State Registrar

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31. Data filed (Month, Dey, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) FOUND 2. Date of Death 3 Time of Death Month 04:50 PM **Physician** GRAY ERNEST B. MARCH 16 1998 /Medical FOUND 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** DISTRICT HEIGHTS #4 DISTRICT PRINCE GEORGES PARKWAY HEIGHTS If Under 1 7. Age (In yrs. lest birthday) 62 yrs. If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 10-01- Birthplace (State or Foreign Country) **Funeral** 100M 2□ F Months Days Hours 229-38-1720 Virginia Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Landover Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7619 Oxman Road 20785 USA Herns 2 11. Marital Status 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Yes 2 No 1952 If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2 X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1973 Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Radio Operator Government 2+ of Haaith and Mantal Hyg If item 27 is marked other or other traumatic event, 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Gray Sr. Gertrude Scott 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 254 Possum Court, Capitol Heights, MD 20743 Pamela Gallion/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Important: If any injury or Arlington National Cem. 3/25/98 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Pencen J.B. Jenkins Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, Applications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, Applications and the death of the mode of dylng, such as cardiac or respiretory errest, Applications and the death of the mode of dylng, such as cardiac or respiretory errest, Applications and the death of the mode of dylng, such as cardiac or respiretory errest, and the death of the death of the death of the mode of dylng, such as cardiac or respiretory errest, and the death of the death o Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final & HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last usa as the burial-tran and Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, physician Physician/Medicai Due to (or es a consequence of): ate has been signed by tha a paga 2 should be detached it Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown SEIZURE PISORDER þ Completed 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? DIABETES MELLITUS completion of cause of death? cartificate has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4□ Nursing Home 5▼ Residence 6 □ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this al or Attending Physics after death.

I Director: After this ed in by the funarel d 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide vithin 24 hours Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. The Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner. Since the samination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner. Since the cause (s) and menner. Since the cause (s) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MARCH 18, 1998 30. Neme and address of person who (Item 23e) (Type, Print) GOLLE MARIO F. JR HOSPITAL PRIVE CHEVERLY, MARYLAND 20785 MD 3001 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 18 19 Registrar

DHMH 16 Rev 6/95

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State Registrar

MAR 18 1998

Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Day **Physician** 12 moon March 1212 1998 Thorton L. Giles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner P.G. Prince Georges Hospital Cheverly If Under 1 Year 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) B. Data of Birth Birthplace (Stata or Foreign Country) **Funeral** 1 M 2 F Days Yrs. Director 578-16-9240 80 11/7/1917 Virginia Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No P.G. Directo MD Seat Pleasant 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20743 U.S.A. 6312 Seat Pleasant Dr. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 11. Marital Status 1- Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Specify: Black 1 Yas 2€ Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) Elementery/Secondery (0-12) Collega (1-4or 5+) 10 Truck Driver Private 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) Flora Fields Walter Giles 19a. Informant'a Nama/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 6312 Seat Pleasant Dr. Seat Pleasant, Md. 2074 Florence Giles wife 20b. Placa of Disposition (Name of camatary, cramatory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Veteran's Cem. 3/18/97 Cheltenham, Md. 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland, Md. 20746 awards 23a. Part. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** lwonary Embolism /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? R- 1/eo/emores 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed HO Cesebrovous enlar Accident 1 TYas 2 No 1 Yes 2 LNd 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Spacify) 1 Dinpatiant 1 Yas 2 No 10 2 ER/Outpatient 3 DOA 28d Dascribe how Injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida edical 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, dete end plece, end due to the causa(s) and manner es stated 29a. Cartifiai (Check only one) 2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and mannar atatad. 29d. Date signed (Month, Day, Year) 29b. Signatura and titia of certifier 29c. Licanse number 148213 M.D 30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print) MD 20716 Bowne Ra # 220 M. ASHAi MiTchellolle 4000 31. Data filed (Month, Day, Yaar) 😘 Ragistrar's Signatura

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Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Theresa P. Higdon March 13, 9:45 PM 1998 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street end number) 4c. County of Deeth Examiner Manor Care - Wheaton Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Yeer)
Oct. 17, 1 5 Social Security Number Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2⊠ F Months 99 Yrs 1898 Washington, DC 577-48-2053 Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Insida City Limite 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner, wast be notified at 1 ☐ Yes 2 No Director MD Montgomery Kensington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3014 Homewood Parkway permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena.
Important: If filem 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Men 20895 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 ☒ No Specify: Specify: p 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Secretary Private Industry 8 18 Mother's Name /First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Paul Schilke Caroline Schombert 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Barbara T. Curran (daughter) 3014 Homewood Parkway, Kensington, MD 20895 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 3/17/98 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 20901 Silver Spring, MD lluin Pert1, enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician /Medicai Immediate Cause (Final CARDIORESPIRATOR diseesa or condition resulting in daath) Examiner Examiner HEART DISEASE THERO SCLEROTIC physician and the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Lest Dua to (or es a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): attending p 88 The law requires that the death 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ۵. Division of Vital Records, by 24b. Wera autopsy findings evelleble prior to completion of cause of death? been sig 24a. Was an autopsy performed? Completed has page 2 2 No 1 Tyes 2 No certificate or Attending Physician: director, 25. Was casa rafarrad to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of After 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No n 24 hours after death. • Funerel Director: Al pletely filled in by the fe after death. 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital edicai 29a. Certifian Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and plece, and due to the causa(s) and manner as stated. Medical Staminer: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. (Check only one) within 2 29b. Signature a 29c. License number 29d. Date signed (Month, Dey, Yeer)

Registrar

Po Co

31. Dete filed (Month, Dey, Year)

30. Pama and address of person who completed cause of death (Item 23a) (Type, Print)
PAWAN K. ARORA MD. KAISER PERMANENTE WASHINGTON HOSP. CENTRE, WASHINGTON DC. 32. Registrar's Signature

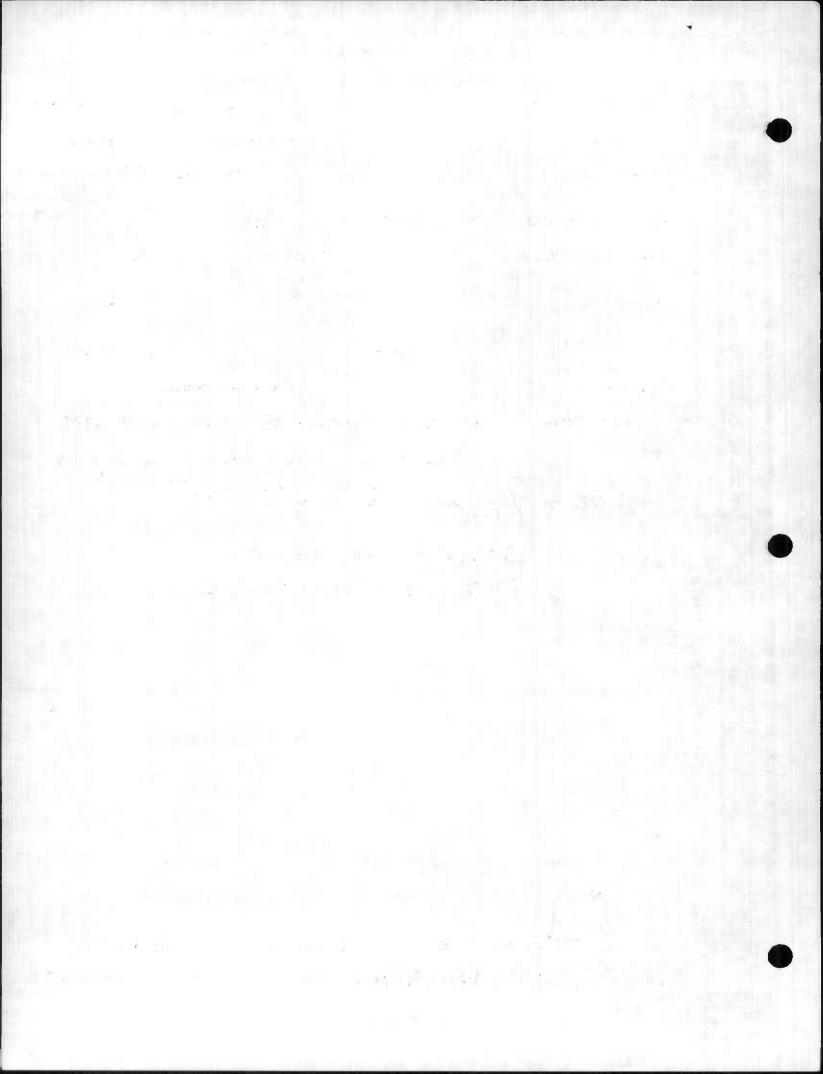
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey **Physician** James T. Hoyle 16, 1998 11:50 AM March /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) 4c. County of Death Examiner ADVENTIST HOSPITAL | Holder 1 Yeer SHADY GROVE MONTGOMERY 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours Min. 1 M 2 □ F Yrs 52 3, 1946 **Director** 213-44-5260 Feb. Washington, D.C Usuet Residence of Decedent the Meryland 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 end 2 should be filed within 72 hours after deeth with nent of Health and Mental Hygiene.
nnt: if them 27 te marked other than "natural", or items 23e or "natural", or items 23s or adical Exercises must be 810 Burdette Road 20851 United States Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 DrDivorced Yeer or Dates: Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Air Conditioning Elementery/Secondery (0-12) College (1-4or 5+) Company 12 Draftsman 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Carl L. Hoyle Alice Dowdy 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) Deborah M. Jackson/Daughter 6411 Kelly Court, Frederick, Maryland 21703 or other 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State March 19, 1998 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If eny injury or 4 ☐ Donetion 5 ☐ Other (Specify) Mt.Zion Cemetery Bethesda, Maryland 22. Name end Address of Fecility Robert A. 21. Signeture of Furierei Sirvica Lican Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, M01126 Rockville, Maryland 20850-2805 ation, thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physicien and the buriel-trensit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or es a consequence of) attending pl signed by the a Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yee 2 ☐ No Division of Vital Records, p 24b. Were eutopsy tindings eveileble prior to Completed 24e. Was en eutopsy performed? completion of cause of death? ate hes this to 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Be Hospitel: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. injury et Work? 27. Menner of Deeth 28e. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 aturel ector; Af 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Sulcide 6 Could not be determined 28e. Plece of tnjury - At home, tarm, street, tectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) ofter 4 \ Homicide To the Hospital of within 24 hours of To the Funeral D completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only 29b. Signeture end titte of certifier 29d. Dete signed (Month, Day, Year) 29c. License number

Snite 212, Olney

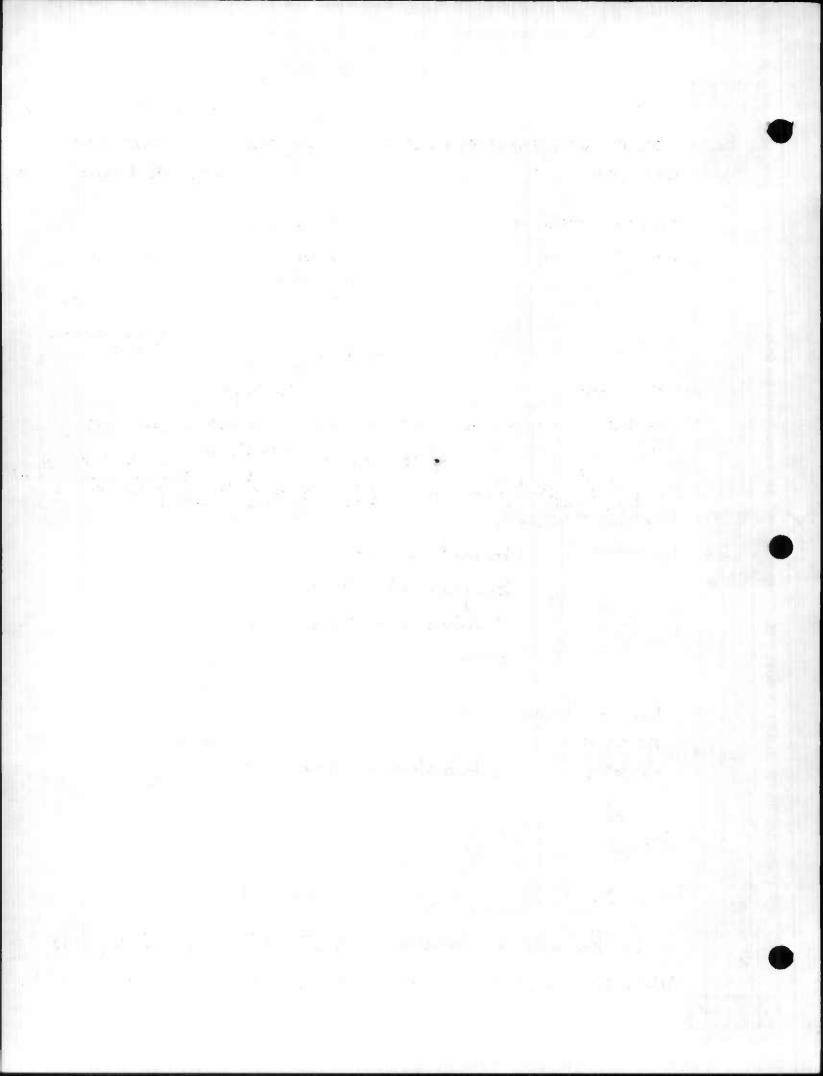
State Registrar 30. Name end address of parson who completed cause of deeth (ftem 23a) (Type Part)

22. Registrar's Signeture

who Davidson-Randalle

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31. Dete tiled (Month, Dey, Yeer)
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State of Maryland / Department of Health and Mental Hygiene

							Cei	rtificate	of L	Death		Reg. No	. 0	100	
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	Exami		-	(If not institution, give	street and nur	nber)			4	b. City, Town, or I		. 1	. County of D		
			HOLY CROSS	HOSPITAL					5	SILVER SPR	ING		MON	VIGOME	RY
	Funeral		5. Social Security			7. Age (In yrs.	lest birthday)	If Under 1	Yeer Devs	If Under 24 Hrs. Hours Min.	8. Dete of B	Birth Year	9.	Birthpiace	(Stete or Foreign
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6,	s 1 and 2 should f Health and Mer Item 27 Is marks other traumatic		19a. informant's N	lame/Relationship (7	ype, Print)			-		RIVE, SILV					(e)
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4	/Medical Examiner		Immediete Causa disease or condition	on	MYOCZ	MYCCARDIAL INFARCTION HOURS									RS
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		ion	1 Naturel	5 Pending	(Mont	of injury h, Day Year)	Injury		Work	?	200. Describe	o now inju	ry occurred		
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)		30. Name end edd	ress of person who o	ompleted caus	e of daeth (Iten	23a) (Type,	Print)							
			PETER S.	BTRK, MD 10	329 CIFOR	TA AVENT	FT_2	या अस्य गाउ	SDDTN	C MADVI N	VID 2000	2 1750	,		

DHMH 16 Rev 6/95

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #2, Per Phy. 3/18/98, Carroll County, wil Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth MAR 13, 98 3. Time of Deeth **Physician** TREVA CATHERINE HOFF 1159 90 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Funeral 1 M 20 F Months Yrs. 220-18-2186 89 Director 12/5/1908 MARYLAND Usuel Residence of Decedent the Maryland 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits MD. CARROLL Funeral Director WESTMINSTER 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3334 HALTER RD. 21158 USA. death 14. Rece - American Indian, Bteck, White, etc. 11. Marttat Status 12. Wes Decedent Ever In U.S. Wes Decadent of Hispanto Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. nnt: if Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coltege (1-4or 5+) 5 HOUSEWIFE HOME MAKER other traumatic avent, 17. Fether's Neme (First, Middle, Last) Be 18. Mother's Neme (First, Middle, Melden Sumame) WILLIAM N. BARBER CAROLINE BITZEL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health e Important: if Item 27 is any injury or other tra EDITH K. WINTERS -DAUGHTER 3334 HALTER RD., WESTMINSTER, MD. 21158 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) TRINITY LUTHERAN CEM.3/16/98 WESTMINSTER, MD. 22. Name end Address of Fecility FLETCHER FUNERAL HOME Service Licenses 254 E. MAIN ST., WESTMINSTER, MD. 21157 and 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, hock, or heert failure. List only one ceuse on eech line. Approximete Intervet Between Onset end Deeth **Physician** /Medical EFT LOWER LUBE PREUMODIA 3 days Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed buriel-transit Sequentiety list conditions, if any, teading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting to deeth) Lest pue Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? signed by t CELLBROUASCOLAR ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? 24e. Wes an eutopsy ISCHEMIC colitis GLAUCOMA certificate hes 21700 1 Yes 2 No 1 Yes Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 □ ER/Outpettent 3 □ DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. injury et Work? 28d. Describe how tnjury occurred After 5 Pending Investigation 1 Neturel death. 1 Yes 2 No efter death 2 Accident in by the 3 Suicide 6 Could not be determined 28e. Ptaca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homtcide 24 hours of Funeral Dietely filled in 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end manner steted. edical 29a. Certifter (Check only one) To the Vithin 2 To the Complete 29b. Signeture end titte of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) Franco K. Galvy Tic mo D31660 13196 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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32 Registrar's Signeture

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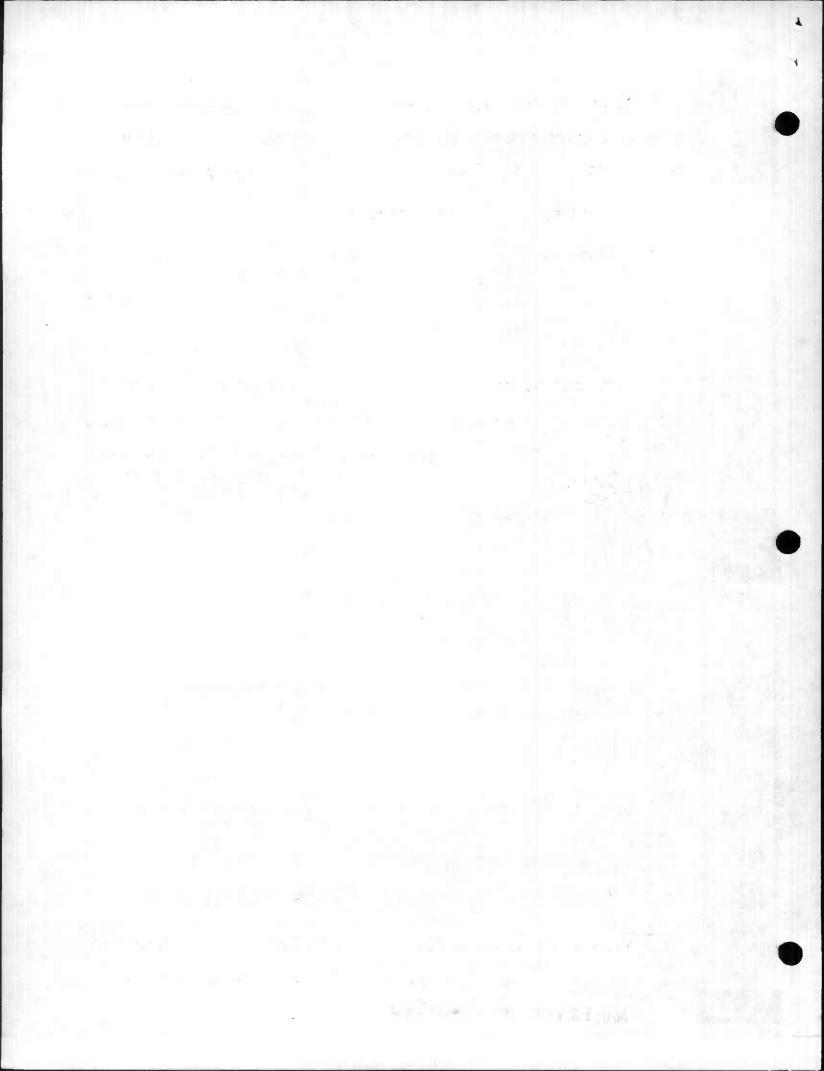
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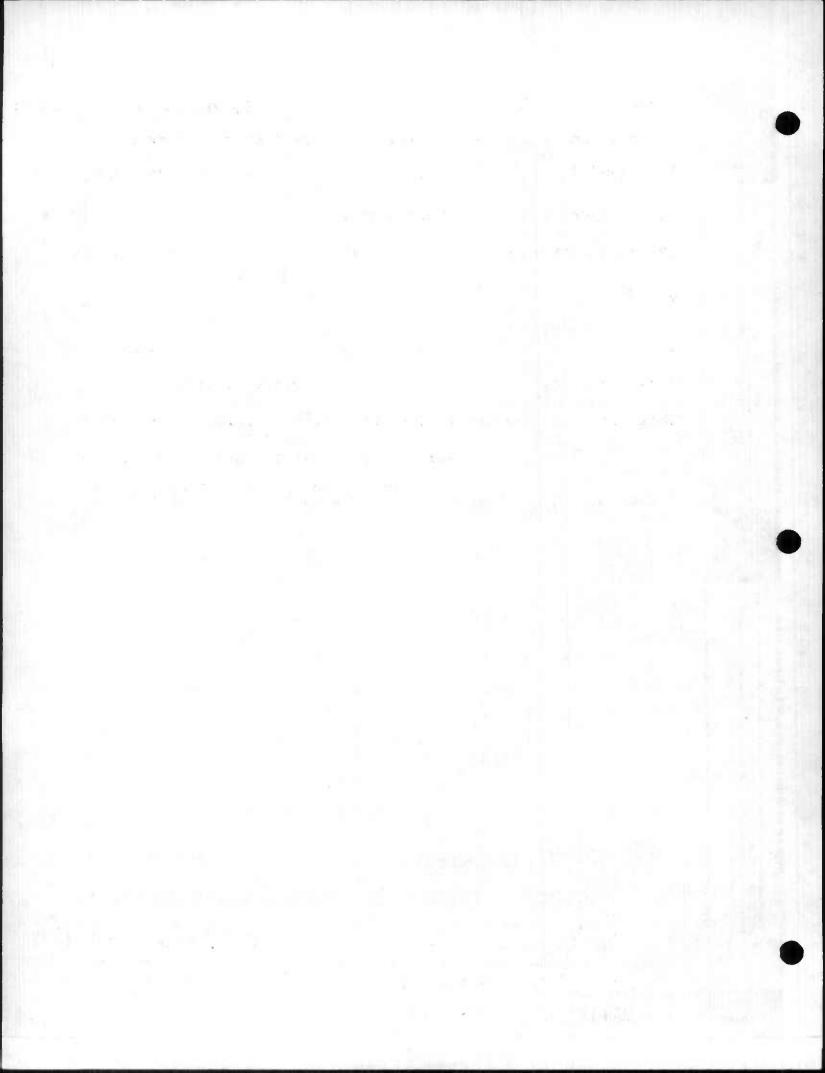
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State of Maryland / Department of Health and Mental Hygiene Q

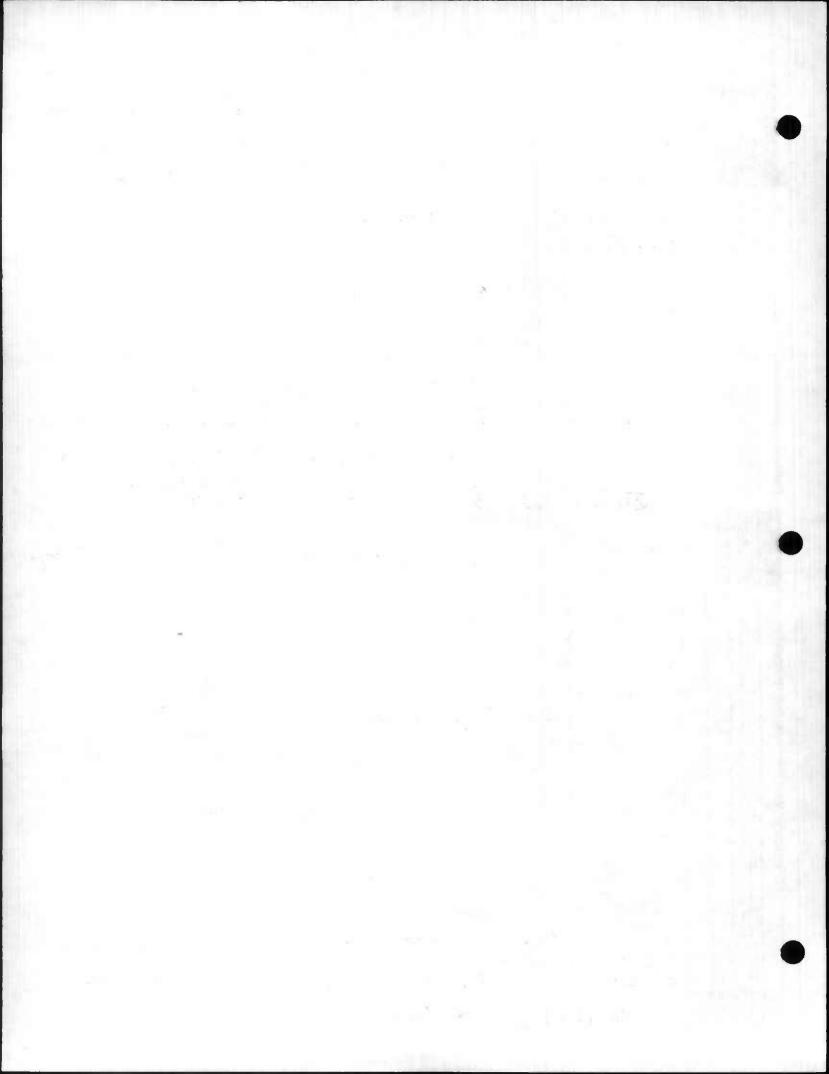
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of the **Physician** 3:45 4 Verna M Hudson MARCON 14 /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Carroll County General Hospital Westminster Carrol1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number **Funeral** Birthpiece (State or Foreign Country) 1□M 2**X** F 73 Yrs. Director 218-18-0398 24 1924 Pennsylvania Aug Usuel Residence of Decadent 10e Stete 10b. County 10c. City, Town or Location 28a-1 show 10d. Inside City Limits Examiner must be notified at MD Director Carroll Westminster 1 ☐ Yes 2 No the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 921 Klee Mill Road 21157 United States death Funerai Herns ? 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 21215-0020 natural, or 1 ☐ Yes 2 No Specify: Completed by Specify: Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Peges 1 end 2 should be filed wittenent of Health and Mentel Hygien tant: If item 27 is marked other the jury or other traumatic event, the Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be John Jacob Frey Cecilia E. Dival 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gail Lee Smith, daughter 1408 High St., Westminster, MD 21158 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 3/18/98 Dete 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signeture of Funerei Servica Licensee 22. Neme end Address of Fecility Pritts Funeral Home & Chapel Kathuric Putts - Successive A12 Washington Rd., We:
23a. Pent. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each interest of the control of the cause of the cau 412 Washington Rd., Westminster, MD Approximete Intervel Between Onset end Deeth **Physician** Heart Failue /Medical Immediate Cause (Finel 41 diseese or condition resulting in death) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest pug Bud buriel-tran Due to (or es e consequence of): P.O. Box 68760, ettending physician use es the Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Minknown Division of Vital Records, b 9 Veripheral Vagaular Disease Completed 24e. Wes en eutopsy pertormed? 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? peen certificate hes 2 12 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury et Work? Medicai Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel r death. 1 ☐ Yes 2 ☐ No 2 Accident efter death the 6 Could not be determined 3 ☐ Suicide 6 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours of To the Funeral D 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier (Check only the 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) 10, 1898 m! March D44505 200 Memorial Ayenue, Westminster, MD 30. Name and address of persorcutto compreted cause of death (Item 23e) (Type, Print) IMPERIAL 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture State Registrar **MAR 16**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						(Certificate of	Death		Reg. No.) [1002	
Dhu	-1-1	_	Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	Year	3. Tima of Death	
	sician edical		Anna May Hy	zy					March			11:10am	
	miner	_	a. Facility Name (If not institution		4b. City, Town, or Location of Death 4c. County of Death								
			Long view nu	rsing ho	ome			Manche	ster	Car	roll		
Funer	ral	٦	5. Social Security Number	6. Sax	7. Age (In	yrs. lest birth	day) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bi			ce (Steta or Foreign	
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er s	Director	5	10e. Street and Number 3007 Bachma:	n Pd			10f. Zip Code			10g. Citizen of 1	What Country	17	
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r des	Funeral		11. Marital Status	12. Was Dece Armed Fo	edent Ever	in U,S.	13. Was Decedent of H If Yes, specify Cube	lispanic Origin? (Span, Mexicen, Puerto	pecify Yes or No Rican, atc.)	o- 14. Rad	e - American		
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Dallimore, N permit. Peges 1 and Department of Heelth Important: If item 27 any injury or other tr	9	Ī	21. Signature of Funeral Sarvice L	_icensee		-	22. Name and Addre	_sh_		e Funer	cal II.	- m o	
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State of Maryland / Department of Health and Mental Hygiene

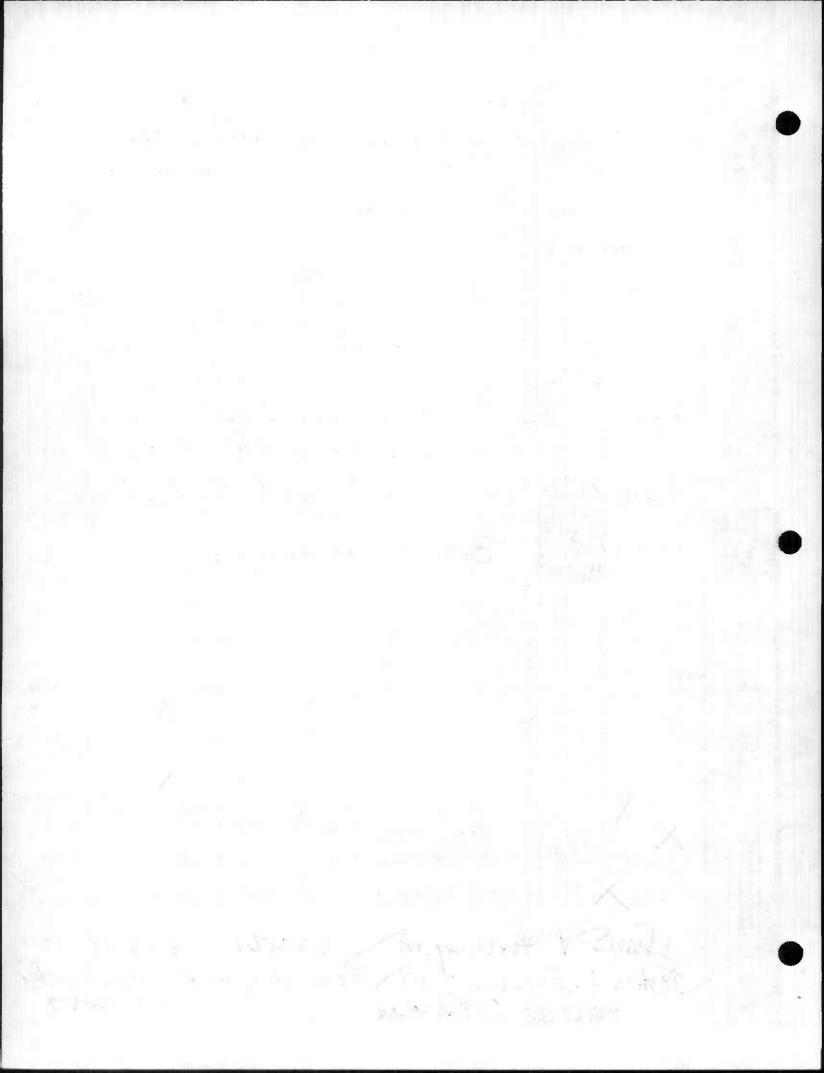
Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth **Physician** March 12ay DOROTHY LEE HAWK 1998 12:50am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Westminster Nursing & Convalesent Ctr. If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Pay, Year) Aug. 13, 1912 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Steta or Foreign **Funeral** Deys Hours 1□ M 2√F Maryland 215-34-0496 85 Yrs. Director Usuel Residence of Dacedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f show MD Carroll Westminster 1 Yes 2 No Director 10f. Zip Code 21157 10e. Street end Number 377 Sunshine Way 10g. Citizen of What Country? With Funeral death 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Never Marriad 2 Married 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates: 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Specify: Caucasian Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) lith and Mental Hygiene. 27 Is marked other than "r r traumatic event, m. Men Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health and Mental Heart: if item 27 is marked oth jury or other traumatic even Be Upton Christian Dayhoff Annie Sophia Frock 9 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Judith H. Seipp/Daughter 370 N. Colonial Ave., Westminster, MD 20b. Plece of Disposition (Name of cemetery, crematory or other plece)
Keysville Union 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or 3/14 Keysville, MD Cem. 21. Signate of Fuperal Service License 22. Name and Address of Fecility Skiles Funeral Home Riles MO0534 21787 136 E. Baltimore St., Taneytown, MD 23e 271. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, nock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onsat and Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner **burial-tran** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): P.O. Box 68760, physician The law requires that the death certificate bethat initiated events resulting in death) Last 200 Due to (or as a consequence of): **USB 88** Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 signed by 3 Probably 4 Unknown Division of Vital Records, ğ 8 Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? n of cause page 2: certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certification: To Be 25. Plage of Death (Check only one) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 100 Maryfor of De at or Att.

Aux after death.

At Director: After the by the funer. 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) led (Month, Day, Year) Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth ^{Day} 998 Month March 7, Charles A. Hocker 4:07 AM 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 1**⊘**M 2□ F Deys Hours 218-82-9680 47 Yrs. July 18, 1950 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Maryland Prince George's Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 928 Nichols Drive 20707-3506 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 11 Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 M Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) None 0 None 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Ralph C. Hocker Mary C. Leary 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ralph C. Hocker (father) Same as 10 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-9-98 Beltsville, Maryland Chesapeake Crematory 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Onset end Deeth Immediate Cause (Finel Pulmonary Hypertension 40+ disease or condition resulting in deeth) Due to (or es e consequence of): Congenital Heart Disease. Ventricular Septal Defect 47 Sequentielly list conditions, it eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Down's Syndrome Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Gastrointestinal Bleeding 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medicai Examiner

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Certification: To

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certificate

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

Items 23a

permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Evantment of Box.

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

traumatic event, the Medical Examiner must be notified at

Examiner Physician/Medicai ģ Completed Be

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpetlent 3 DOA 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

29a. Certitier onel

MAR 18 1998

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of periller

29c. License number 29d. Date signed (Month, Dey, Year)

D 10205

March 16, 1998

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print)

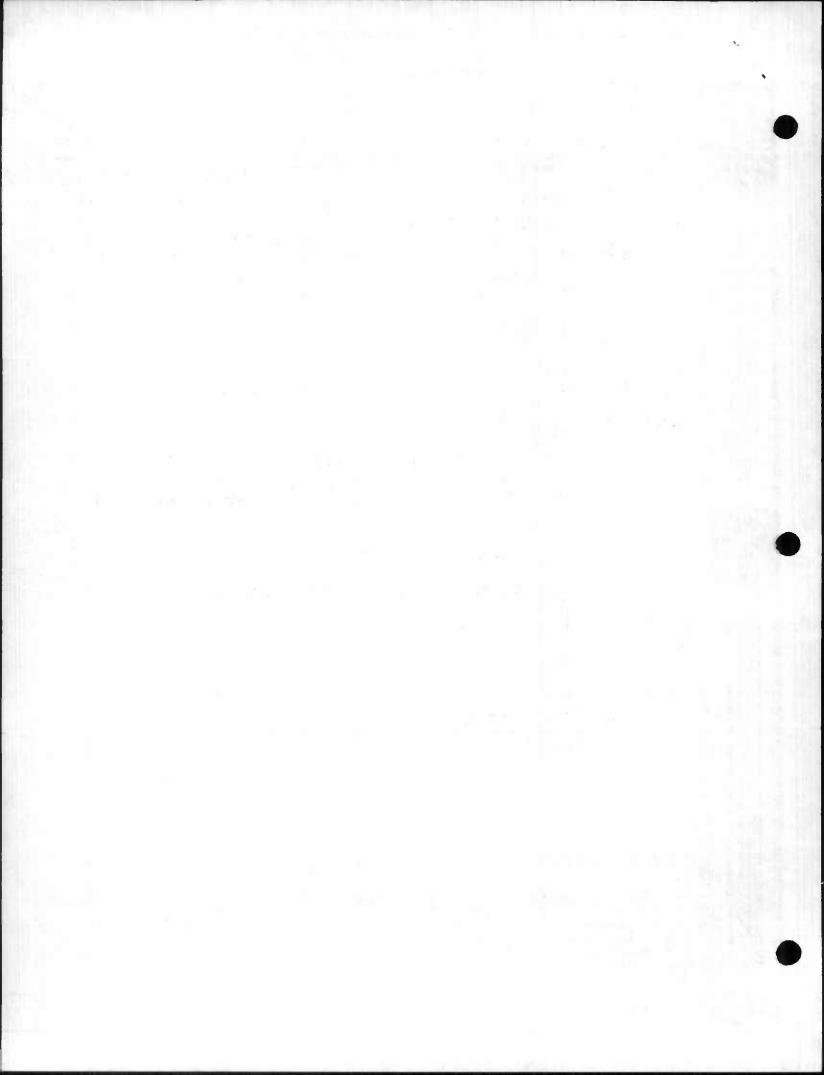
Stanley M. Silverberg, M. D., 5454 Wisconsin Avenue, #925, Chevy Chase, MD 20815 31. Dete filed (Month, Day, Year)

State Registrar 32 Registrer's Signeture a Davidson

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7, 3/16/98, BMW, Montg. Co. Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death Month **Physician** MARCH 11, 1998 ANNE HERSKOWITZ 3:20 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 20 F Yrs. Director 053-30-1416 MARCH 2, 1904 LONDON Usual Residence of Decedent with the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6121 MONTROSE ROAD 20852 UNITED STATES OF AMERICA Funeral 2 should be filed within 72 hours efter deeth end Mental Hygiene. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) NATHAN GORDON FANNIE FRIEDMAN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) . Pages 1 and 2 si iment of Health en-tant: If Item 27 ia r jury or other traus CAROL KOPIT/DAUGHTER 5800 NICHOLSON LANE, ROCKVILLE, MARYLAND 20852 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State important: If its any injury or o pnce. 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State Department RIVERSIDE CEMEITERY 03/13/98 SADDLE BROOK, NU 4 □ Donetion 5 □ Other (Specify) 22. Neme end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Ente complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, rent. Enter the dispute, or shock, or heart fe time. List Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Jement Examiner Due to (or as e consequence of): Examiner physician and s the buriel-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760. Physician/Medical thet initieted events resulting in deeth) Last Due to (or es e consequence ot): as t 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Ninknown signed t Records, δ 24b. Were autopsy findings evelleble prior to 24e. Was en autopsy performed? Completed completion of cause of deeth? certificate has t 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of 28d. Describe how injury occurred 27 Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. injury et Work? Certification: After or Attanding 1 Naturel 5 Pending 1 | Yes 2 | No r deeth. investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 C Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 Homicide after 24 hours Hospital 29a. Certifier 📆 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as steted. To the Hosp within 24 hou To the Fune completely fi edical 2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete and place, end due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifie 29d. Date signed (Month, Dey, Year)

Morrivose Pd., fockville MD 20852

State Registrar 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Feldman

31. Dete filed (Month, Dey, Yeer) MAR 16 1

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Comments of the

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death 2200 WICOMICO Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No USA 14. Race - American Indian, Black, White, etc. Specify: White Hebron, MD Approximate Interval Between Onset and Death 4 days 1400 V 2 weeks 24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

altimore. Box 68760 P.O.

Examiner Funeral Director the Maryland in than "natural", or items 23s or 28s-1 show Directo with Funeral should be filed within 72 hours aftar 00 Maryland 21215-0020 by Completed al Hygiena. other traumatic event, Be with and Mental I P 1 and 2 permit. Pages 1 and 2: Department of Health at Important: if Item 27 is sny injury or other tracence. **Physician** /Medical Examiner Examiner certificate be executed physician and s the burial-trans Physician/Medical 20 980 for 2 Records, þ Completed Division of Vital Be 10 this funeral Certification: Attending aftar death. Director: Aft

Certificate of Death Amended #11 WCHD 3/16/98 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PEARL MARGARTEN HARMON 5,1998 4b. City, Town, or Location of Death · /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 6 Sex Days 10 M 25 F Months Hours Yrs. 216-12-2689 5/21/15 82 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31810 Melson Road 21875 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: -15 Never-Married 2 Married 1 Yes 2 No Specify: 3. Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Shirt Factory **SEamstress** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) James Parsons Ella Huntington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Betty Layfield/Daughter 31810 Melson Rd., Delmar, MD 21875 20b. Place of Disposition (Name of cometery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removel from State Springhill Memory Gardens 3/12/98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June al Service License 22. Name and Address of Fecility
Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Applications and the second Immediate Cause (Final disease or condition resulting in death) MRSA SEPSIS Due to (or as a consequence of): CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PAROTID ABSCESS Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown SKINDSIS Witical Aurhic 24e. Was an autopsy performed? 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier Nathan mi 3/10/58 141094 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) V. NATESAN, MD - PRMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature

White tweeless Rardall

MAR 12 1998

Registrar

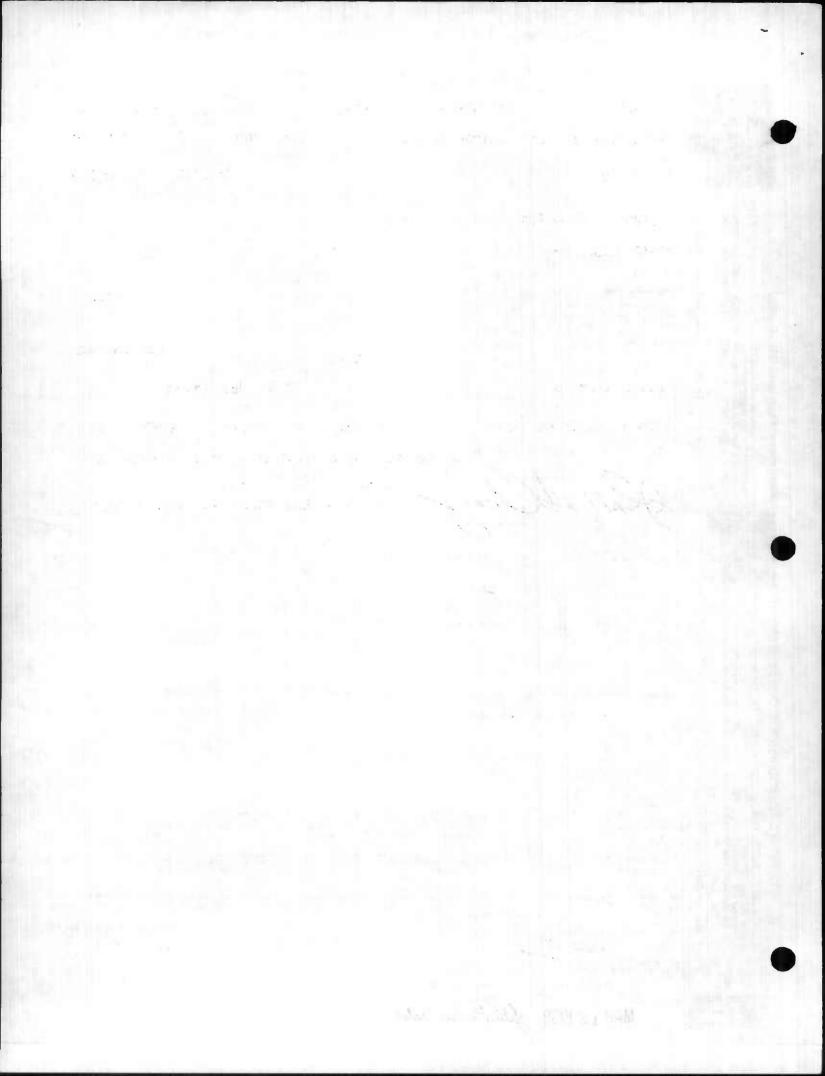
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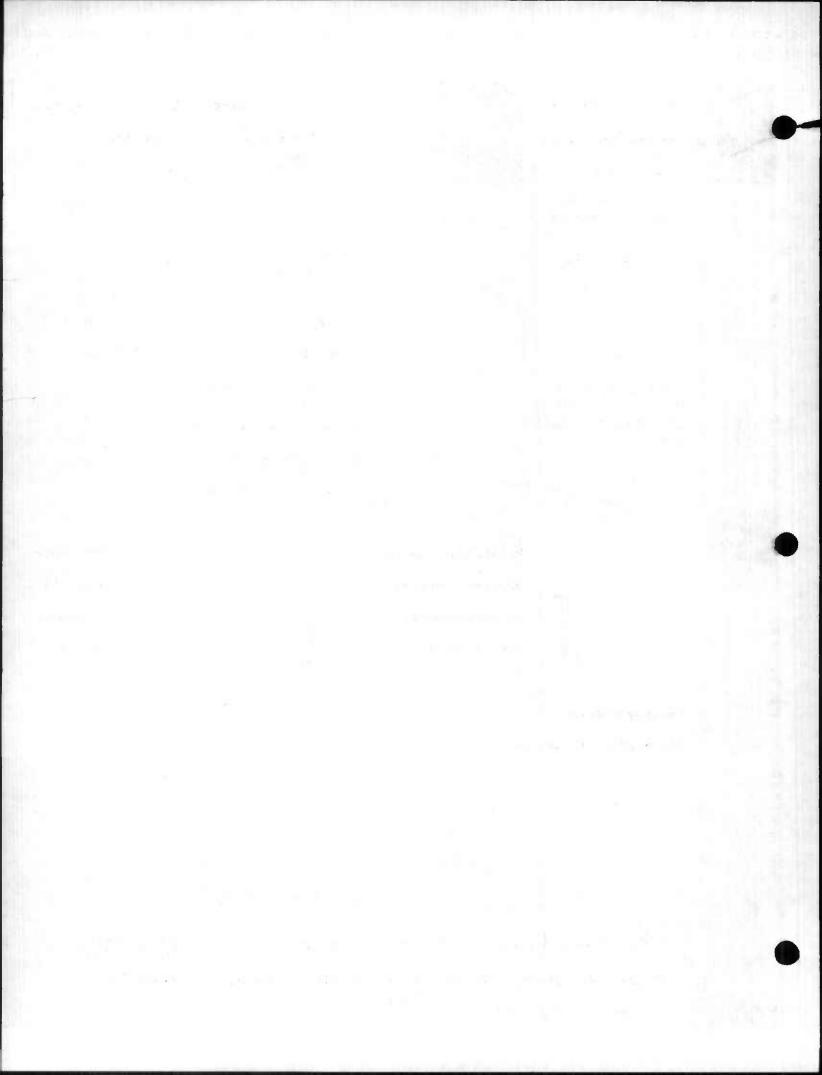


State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Carrie B. Hunter March 1998 1:35 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Deer's Head Center Salisbury Wicomico if Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 2MF Days Hours 254-44-8349 Yrs. Director 66 Sept 10, 1931 GA Usual Residence of Decedent the Merylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner munt be notified at 1☐¥es 2□No Director MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8658 Poole St. Funeral 21875 U.S. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. Pages 1 end 2 should be filed within 72 hours efter onen'd Health and Mental Hydison.
Interfitem 27 is marked other than "natural", or flei interfitem or other traumatic event, the Medical Earning into or other traumatic event, the Medical Earning into or other traumatic event, the Medical Earning. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 7th College (1-4or 5+) Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Walter Williams Queenie Brooks 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Ernest Hunter/husband 8658 Poole St., Delmar, MD 21875 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriai 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 3/14/98 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Pert in er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervai Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Respiratory failure Immediate Examiner Due to (or as a consequence ot): Examiner Massive anasarca 6 months physicien and s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Hypoalbuminemia 12 months P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): Morbid obesity years 98 signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Hypothyroidism Records, g Be Completed 24a. Was en eutopsy performed? Were autopsy findings available prior to Diabetes mellitus, type II completion of cause of death? page 2 2X No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Deeth 1 Natural 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UNDans D33905 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Virginia A. Dulany, M.D., CMD, P.O. Box 2018, Salisbury, MD 21802-2018 31. Date filed (Month, Dey, Year)

State Registrar MAR 13 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month **Physician** Norman Lee Hawk 2205 8,1998 MARCH /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. June 27,1927 Philadelphia, PA If Under 1 Year 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral ™** M 2□ F Months Deys 70 Yrs. **Director** 207-14-9658 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Med cal Examiner must be notified at 1 ☐ Yes 2 K No Millsboro Delaware Sussex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 72 N. Pine St., Bay City 19966 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2X No Specify: Specifyhite I Hygiene. other than "natural", c by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) oil burner sales Sales estimator 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 Atville C. Hawk Sara McIlvaine 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2 and 2 and 2 in and 2 in an important: if item 27 is a my injury or set 72 N. Pine St., Bay City, Millsboro, DE 1986 Myrtle C. Hawk, wife 20b. Place of Disposition (Neme of cametery, cremetory or other place)

Eastern Shore Crematorium 3/12/98 Lewes, Delaware 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name end Address of Fecility Parsell Funeral Homes & Crematorium 1449 Kings Highway, Lewes, DE 19958 Lead on your council control of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, that only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner 720czr diz, Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical onc 00 Due to (or as a cosseo ce of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy Completed completion of cause of deeth? 2000 1 TYes 2 No. 1 Yes 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospitel Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 9 1 Yes 2 No 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760,

physician and the burial-transit certificate be 88 esn signed by the a d be detsched f page 2 s certificate or Attending Physician: director. funeral After filled in by

the Marylar

death

2 should be fill and Mental H

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Maryland 21215-0020

timore,

unno

24 hours after death. Funeral Director: Af Hospital within 2

> State Registrar

31. Dete filed (Month, Dey, Yeer)

MAR 13 1998

29a. Certifier

(Check only one)

29b. Signature and title of

Medical

RAFFETTO 32. Registrer's Signature Jaki Davidson Rardall

completed cause of deeth (Item 23e) (Type, Print)

29c. License number

29d. Dete signed (Month, Dey, Year)

D 20441

403 away Street Salisbury md

1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

DHMH 16 Rev 6/95

		Item:12 per F.H.G-758		arylark	Cer	tificate o	Health and f Death	wichtarriy	Reg. No.	10	069		
Physici /Medic		Decedent's Neme (First, Middle, Las WJ_LLIAM HENRY F.						2. Date of Do Month MARCH	Dey	Year	3. Time of Death 5:30 pr		
Examin	ner	4a. Facility Nama (If not institution, give 4534B REEVES PL	street and number	r)	-		4b. City, Town, or		th 4c. County	of Deeth			
Funeral Director		5. Social Security Number 6. Security Number 237–30–1824		nge (In yrs. la 73	ast birthday) Yrs.	If Under 1 Yas Months Dey		s. 8. Date of Bi	rth	9. Birthplac Country CAROLI	o NORTH NA		
tha Maryland 28a-f show	J.	Usuel Residence of Decedent 10a. Stete 10b. County MARYLAND CHARLE	c		, Town or Loc	ation				100	. inside City Limi		
28a-f	Director	MARYLAND CHARLE:	5	WAL	DOKE	10f. Zip Code			10g. Citizen of V	Og. Citizen of What Country?			
th with 23a or		4534 REEVES PLACE	E APT. B			2060			UNITED				
after dea or Items	by Funeral	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedan Armed Forces 1 2 Yes 2 If Yes, Give 1 Year or Dates	? I No	if	/es Decedent o Yes, specify Co □ Yes 2 N	f Hispanic Origin? (uban, Mexicen, Pue o <i>Specify</i> :	Specify Yas or Norto Rican, etc.)	Bled	e - American ck, White, at BLACK			
within 72 hours ena. then *netural*, he wed call Ex-	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12)	College (1-4or 5+) (Give life. L			dent's Usuel Occupetion kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry				
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e d is b	To Be	17. Fethar's Neme (First, Middle, Last) ROBERT HOWARD SR				KATIE F	FARMER HO	OWARD					
pas 1 and 2 should of Haalth and Mer if Itam 27 is marke or other traumatic		19a. Informent's Name/Rejetionship (T MARY A. HOWARD /			4534	REEVES	et end Number or F		Der, City or Town,				
gas 1 If itan or oth		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐	Ramovai from State	00	ace of Dispos metery, crem	ition (Name of atory or other p	lace)	Date	20c. Location -	City or Town	, Stete		
t. Pa rtman rtant: njury		4 Donetion 5 Other (Specify		ARL				3/30/98	ARLINGT	ON, VI	RGINIA		
permit. Pagas Department of Important: If it any injury or once.		21. Signature of Funerel Service Licensee 22. Name and Address of Fecility THORNTON FUNERA 3439 LIVINGSTON ROAD INDIAN HEA									P.A. 20640		
Physician		23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only of	licetions that cause one ceuse on eech	ed the deeth. line.	. Do not ente	r the mode of d	ying, such es cardie	ac or respiretory e	errest,	i Ir	pproximate itervei Betwaan insat and Deeth		
/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death) e. LUNG CANCER WITH METASTASIS Due to (or as a consequence of):											
cuted nd ransit	Examine	Sequentially list conditions.	b. — Due to (or as a consequence of):										
cata be axecuted bhysiclan and the burial-transit	dical Ex	Sequentially list conditions, if eny, leading to immediata ceuse. Enter Undarlying Cause (Disease or injury that initieted events											
death certificate a attanding physical of for use as the		a											
death a atta ed for	sicia	Pert II. Other significant conditions co	ntributing to deeth	but not resui	itino In the un	derlying causa	givan in Part I.	23b. Did	tobacco use co	ntribute to ti	ne cause of deat		
s that the death certification of the death	by Physician/M								Yes 2□No				
a law requiras that has been signed to ga 2 should be dat	Completed b							24a. Was perf	an eutopsy ormed?	24b. Were avella comp of de	eutopsy findings able prior to eletion of cause eth?		
The ata	Сош							10	Yes 2 No	101	'es 2□ No		
ysician: The	Be	25. Was cese referred to medicel exeminer?	Magnital					ath (Check only	one)				
this aldi	ion: To	27. Menner of Death	Hospitel: 1 Inpat 28e. Dete of In (Month, D		R/Outpatient 28b. Time of injury	28c. In	jury at ork?	Ing Home 5 Residence 6 □Other (Specify) 28d. Describe how Injury occurred					
or: or: tha	Certification:	2 D Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Plece of Ir	njury - At hon tc. (Specify)	ne, farm, stre		□ Yes 2 □ No e	28f. Location (Street end Number or Rural Route Number, City or Town, State)					
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 4E Certifying Phy 2 Medical Exami	alclan: To the best iner: On the basis and menner s	of examinetic	riedge, death on end/or inve	occurred at the estigation, in my	time, date and piac opinion, deeth occ	e, end due to the surred et the time,	cause(s) and ma date end place,	nner as statendered due to the	ed. e cause(s)		
To the within To the	Me	29b. Signeture end titla of certifier	М-	128	h~		nse number 28352		29d. Date signed (Month, Day, Year) MARCH 19 1998				
	D28352 30. Neme and address of parson who completed ceuse of deeth (Item 23e) (Type, Print)									MARCH 19,1998			
		KRISHAN MATHUR	M D	D O	POV		T 7 DT		20646				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Month **Physician** HASKIMS Marie 1:35PM March 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** 82 ta Hawthorne rarles Koad -0 10 if Under 1 Yeer if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day) Birthplece (Stata or Foraign Country) **Funeral** 1 □ M 2 KF Months Deys Hours 578-80-0949 38 Yrs. 11,1959 WASHINGTON,D.C. Director Usuei Residence of Decedent the Marylend 10e State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MARYLAND CHARLES LA PLATA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7825 HAWTHORNE ROAD 20646 UNITED STATES Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Peges 1 and 2 should be filed within 72 hours after or nent of Health end Mental Hygiene. nt: If Item 27 is marked other than "natural", or Itel XXNever Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: BLACK by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 2 YEARS EXECUTIVE ADMINISTRATIVE ASST. 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumema) HAROLD HASKINS ALICE MARIE COLEMAN JOHNSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2.
Depertment of Health er
Important: if Item 27 is
any Injury or other trau BEVERLY B. EJINIWE/ MOTHER 7825 HAWTHORNE ROAD, LA PLATA, MARYLAND 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State HUNTT CREMATORY 3/19/98 WALDORF, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
THORNTON FUNERAL HOME, P.A. THORNTON JUNESON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. MDIA C. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximeta Interval Between Onset end Death **Physician** /Medical Cancer of Pericardium and Lung Immediate Cause (Final 10disease or condition resulting in deeth) Examiner Examiner physician and the buriel-transit The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Physician/Medicai Due to (or es e consequence of) ettending properties of signed by the e Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? should Completed 24e. Wes en eutopsy performed? page 2 1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after deeth. Funerel Director: After this certifics stely filled in by the funeral director, is 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Chack only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medicai Certification: To 1 Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Dete of Injury (Month, Day Yeer) 27. Mennor of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 1-ENeture 5 Pending 1 Yes 2 No 2 Accident Investigetion 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homleide To the Hospital within 24 hours a To the Funerel Completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

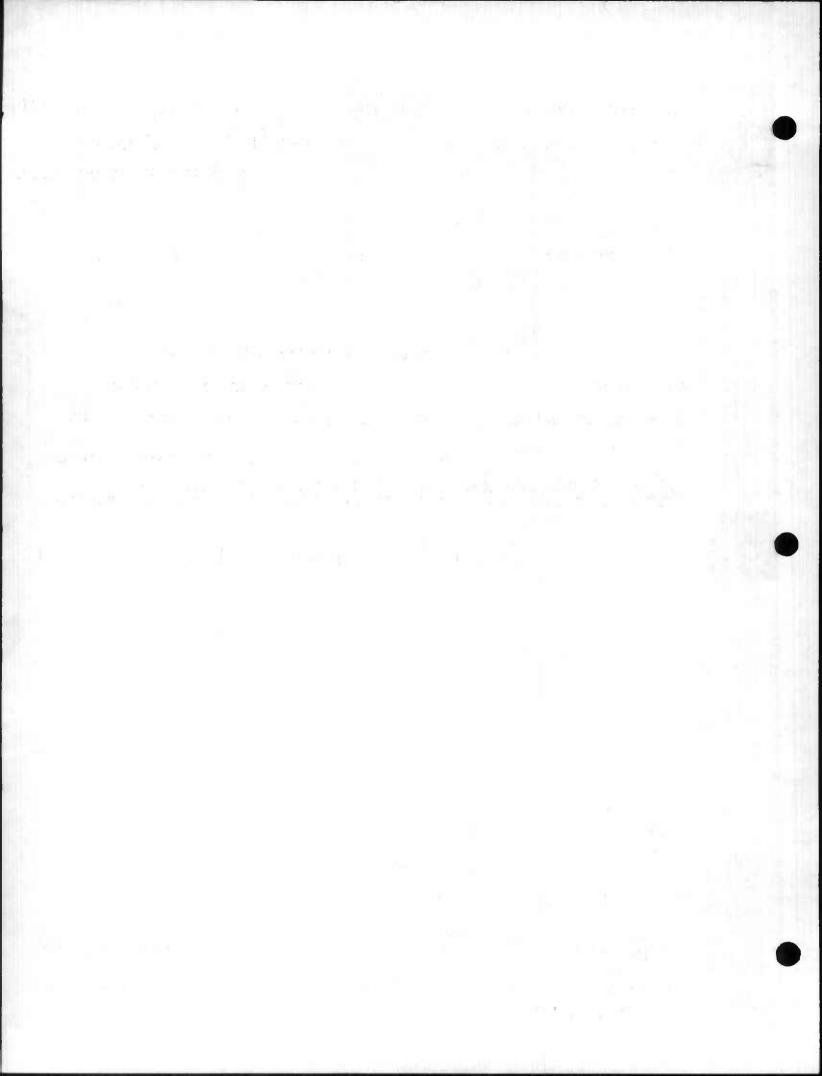
of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

ROX

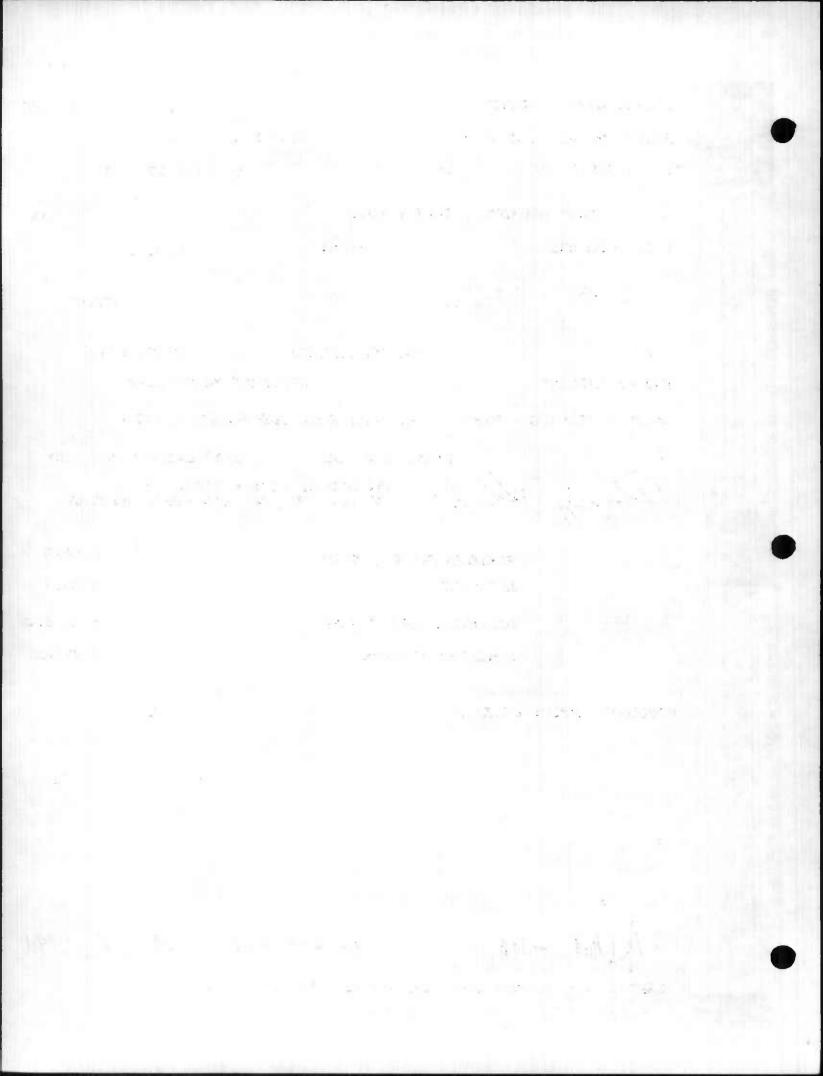
2729, La Plata, MD 20646

State Registrar



State of Maryland / Department of Health and Mental Hygiene Gertificate of Death

					Cen	meate of	Dealli		Reg. No.				
Physician	DONALI	1. Decedent's Nama (First, Middle, Last) DONALD EDWARD HIGGINS						2. Data of Month	Day Year				
/Medical Examiner	4a Facility Neme (If not institution, giva street and number) HARBOR HOSPITAL CENTER							, or Location of De	of Deeth 4c. County of D				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24						Hrs Dote of						
rland	Usuel Rasidence 10a. Steta	10b. County		10c. City, To						1	10d. tnside City Limits		
28a-f ahow	MD		RUNDEL	GLEN	BUI						1 □ Yas XXV		
23a or 2	10e. Street and N	ROWE DRIV	Έ	10f. Zip Code 21 061						What Coul	ntry /		
thar dear thems	11. Marital Stetus	mied XXMarried	12. Wes Decedan Armad Forcas 1 Vas 2 the Yes, Giva Yaar or Date	?		es Decedant of Yas, specify Cul		n? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra Bla Specii	cen indian, atc.			
ed within 72 hours 8 ygiens 4 ygiens 4 ygiens 6 ygiens 7	3 ☐ Widowed	4 Divorced	ucation		a. Decede	nt's Usual Occu	petion		16b. Kind of E		ITE dustry		
C 48 100	(Sp Elemantary/Se	ecify only highast grad condary (0-12)	da complatad) Collaga (1-4or		life. Di	ind of work done O NOT usa ratin	ed)	f working					
	12 17. Father's Nam	e (First, Middle, Last)		P	OLIC	CE OFF		Nama (First, Mide	BALT.		'Y		
Mantal H Marked out atto ever	THOMAS	HIGGINS	•				MARG	ARET Mc	CONCILI	E			
nd 2 saith ar 27 is r trau	19a. informent's	19a. Informent's Name/Reletionship (Type, Print) LAVERNE HIGGINS - WIFE 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1434 ROWE DRIVE, GLEN BURNIE, MD 21061											
permit. Pagas 1 al Department of Hae Important: if item any injury or othe once.		1 Burlei 2 ☐ Cremation 3 ☐ Removal from Stata				ition (Nama of story or other pl		Data	20c. Location				
permit. Pagas Department of Important: If it any injury or once.	4 Donetlor	5 Othar (Specify)	BALT	-	AT. CEI		3/12	CATONS	VILI	E, MD		
Pemit. Depart. Importa	23a. Part1. Enta shock, or he	r the disaase or come eart failura. It only c	scations that cause one cause on each	ed the death. Do	42	6 CRAIN	HWY.	NK FUNE SW, GLEN ardiac or respireton	BURNIE.		Approximete interval Batween Onsat end Death		
/Medical Examiner	Immediate Ceus disaasa or condi rasulting in daath	tion	a. GASTR	OINTEST	INAL	BLEEDIN	G			1	2 DAYS		
		,	LIVER FAILURE								2 DAYS		
at the death certificate be associted by the attending physician and lateched for use as the burial-transit Physician/Medical Fyamines	Sequantially list of the sequentially list of the sequentially list of the sequential se	conditions, immadiate darlying or injury	METAS	Due to (or es a		Heath and					3 MONTHS		
n certificate be an adding physician s use as the burial.	that initiated avar rasulting in death	nts	METAS	Due to (or es e consequence of): METASTATIC MELANOMA							2 YEARS		
the attenthed for under	Pert ii. Other sign	nificant conditions co	ntributing to deeth	but not resulting	in tha und	darlying ceusa g	ivan in Part I.	23b. D	fd tobacco use co	ontribute t	o the cause of deat		
											obably 4 Unknow		
v requiras l been signi should be						_		24a. W	as an autopsy enormed?	av CC	/are autopsy findings vailebla prior to ompletion of cause i death?		
vician: The lav lician: The lav certificata has rector, paga 2								1	Yes 2 No	1	□Yas 21 No		
Iclan: certific rector	25. Was case raf		Hospital:			0	ther	f Death (Check on					
2 00		1 Yes No Hospital: inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (S). 27. Mannar of Death 28s. Date of Injury at 1 Sec. Injury at									ify)		
tal or Attending P is after death. al Director: After ted in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide									bar or Rur	rei Route Number,		
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification:		1 Certifying Phy 2 Medical Exam	raician: To the besiner: On the besis and mannar s	of axemination e									
To th Withir To th comp	29b. Signaturi ar	Quil	-40,				L44	16 14	29d. Data sign		Day, Year)		
		drass of person who c											
Chaha		onth, Day, Year)	ARBOR H	OSPITAI	CE	NTER	BALTI	MORE, M	D				
State Registrar		MAR 13 199	8 goin	trar's Signatura,	Pande	02							

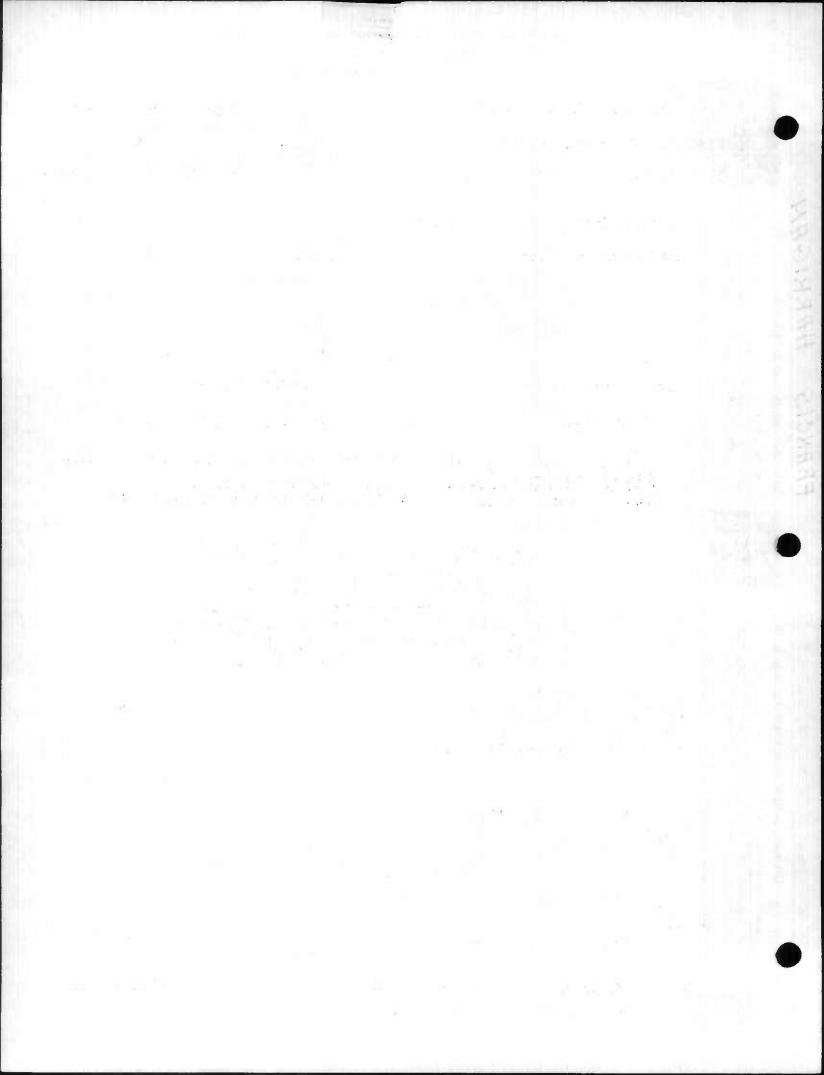


State of Maryland / Department of Health and Mental Hygiene 8

10072

				,	C	ertificate o	f Death	,	Reg. No.	10	016
	Dhuaic	2.5	1. Decedent's Neme (First, Middle, La					2. Dete of D		Yeer	3. Time of Deeth
Physic /Med			FRANCIS JOSEP	H HARRIGAN				MARCI			6:15 AM
	Examir		4e. Fecility Neme (If not institution, giv	'e street and number)			4b. City, Town, or			ty of Deeth	
			CIVISTA MEDICAL	CENTER			LAPLATA			ARLES	
	Funeral Director		5. Social Security Number 6. S 158-01-9297	Sex 7. Age (In yrs. 0XDXM 2□ F 81	. lest birtho	Months Dev			rth ey, <i>Year</i>) 12, 1916	Couin	lece (State or Foreign ito) ington DC
	puel * =		10a. Stete 10b. County	10c. C	ity, Town o	r Location				1	0d. Inside City Limits
	Mary	Director	Maryland Charles	M:	aldor	f					1 ☐ Yes 2√ No
	the		10e. Street end Number	WC	11001	10f. Zip Code	-		10g. Citizen of	f What Cour	
	3a or		3505 Smoke Tree	Court			20602		US		,
21215-0020	me 2	Funeral	11. Maritei Status	12. Wes Decedent Ever in U Armed Forces?	J,S.	13. Wes Decedent of If Yes, specify Cu	Hispenic Origin? (Specify Yes or N	o- 14. Re	ece - Americ	an indien,
	72 hours after death with the Marylend "natural", or flerns 23a or 28a-f ahow ideal Examinat must be nettred at	þ	1 Never Merried XX Married 3 Widowed 4 Divorced	Armed Forces? 1XX es 2 □ No If Yes, Give Year or Dates: 1939	i	if Yes, specify Cu 1 ☐ Yes 2X N		rto Rican, etc.)	Spec	iack, White, Wh	White White
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ecedent's Usuel Occ	upation e during most of w	orkina	16b. Kind of	Business/Ind	justry		
121	withln ene. than "	mpi	Elementary/Secondery (0-12)		Give kind of work don fe. DO NOT use reti		J. King	_			
7	70 00		12 17. Fether's Neme (First, Middle, Lest)		l R	epairman	"A"		Pepco		
and	e da b	To Be	Daniel James Har					eme <i>(First, Middle</i> t Jochiu		ime)	
Maryland	2 should end Men is marke		19e. informent's Neme/Reletionship (10b A	lailing Address (Stre				- Ctata Zia	Code
Ma	47		Ann E. Harrigan	Typo, Thilly		505 Smoke					C00e)
re,	-I 55		20e. Method of Disposition	20b.		isposition (Neme of cremetory or other p		Dete	20c. Location		wn, Stete
altimore,	age Hit o		1 Denies 5 Other (Specification)		inity	Memorial	Gardens	l			
Ba	permit. P Departme Important any injuri		21. Signed relative for Service ficer Mark G. Broha	wn M00053		Huntt Fund P. O. Box			20604-	-0156	
			23a. Pert1. Enter the diseese, or com shock, or heert feilure. List only	pilcations that caused the dee one pause on each line.	th. Do not	enter the mode of d	ylng, such es cardia	c or respiretory	errest,	1-	Approximete interval Between
	Physician /Medicai		Immediate Cours /Final	() occopy	0/10	Doula	. AAA	i Dont	-	i	Onset end Death
1	Examiner		immediete Ceuse (Finei diseese or condition resulting in deeth)	. LIVEUN) VV	W ema	1140	1 accu	-		
		ē		DO A DO AC	THE SE	reaquence of):	- 10112	-0		1	
	insit	Examiner	an annum car	PICALLIC	UU	74. 10	uyu.	4		-	
Ć.	exect in and fel-tra	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	01101	- (3000	OWIDE	MANT	TILL	- 1	
68760,	rtificete be executed ng physician and s es the buriel-transit		triet initieted events	c. Due-to-ft	r as a cor	SHUTHUR III)	Cvag	Upa	my	- 1	
	ing phy e es th	Medical	resulting in deeth) Lest	XI CON S	ZILV	110	in short	110	1	- 4	
Box				d. of the C	SIA	W 04	MAINY	we		-	
	0 0 0	Physician/	Pert ii. Other significant conditions of	ontributing to death but not rec	sulting in th	e underlying ceuse of	iven in Pert i.	23b. Did	tobacco use c	ontribute to	the cause of death?
P.O.	by the	² hy:	Massino	monain A	10	adina			Yes 2 No	-	pably 4 Unknown
	S 5 8	by	infrom 14 C	Survice of	ree	anny					
of Vital Records,	v requires been sign should be	Completed	& Caboles	Mollita	Λ.	1		24a. Wes	s en autopsy omed?	eve	ere autopsy findings eileble prior to
ec	2 S C	ple		· 10 · oc low	J .					of c	mpletion of cause deeth?
<u> </u>	T age	Son						1 🗆	Yes 2000	10	Yes 2 No
/ita	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical exeminer?				26. Place of De	eth (Check only	one)		
of	5 00	2	1 ☐ Yes 21 No		ER/Outpa	tient 3LI DOA		Home 5□ Res	idence 6 🗆 O	ther (Specify	0
	After Iuner	inol :	27. Menner of Deeth 1	28a. Dete of injury (Month, Dey Year)	28b. Tim inju	ry W		28d. Describe	how injury occu	urred	
Sic	Attending ir deeth. ector: After by the fune	Icat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				Yes_2 No	004 1 1'	(0)		
Division	or Attendation of Director:	Certification:	4 ☐ Homicide determined	28e. Piace of injury - At h building, etc. (Special	fy)	, street, fectory, office	9	City or To	wn, Stete)	iber or Hure	I Route Number,
	Hospital 24 hours Funeral stely filled	- 1	29a, Certifier Photography Physical Physics (1994)	voicion: To the best of my key	udodeo d	and an automated at the	time data and size		/ . /		
	the Hospital hin 24 hours the Funeral upletely filled	edlcai		yeician: To the best of my kno niner: On the basis of examine end menner steted.	etion end/c	r investigetion, in my	opinion, death occ	e, end due to the urred et the time,	dete end placa	nenner es st	the cause(s)
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	M	29b. Signature and title of enrifier	/		29c. Licer	nse number		29d. Date #gn	ed (Mont#, I	Day, Year)
	F > F 0		N///	1/110			D 00001		3/1	9/1	20
			30. Neme end eddress of person who o	completed cause of death /ltm	m 23a) /Tu		D-23021		1	(10
			SANJEEB MISHRA M.D				C POST OF	יהורה פרוקי	D MAIN	JBE WD	20602
	Sta		31. Dete filed (Month, Day, Year)			THITT /-	O TOST OF	TICE KUF	אעדיה(JKT FID	. 40004
	Registr		MAR 2 0 19	198 Julia de leve	diar R	what					

FRANCIS HARRIGAN

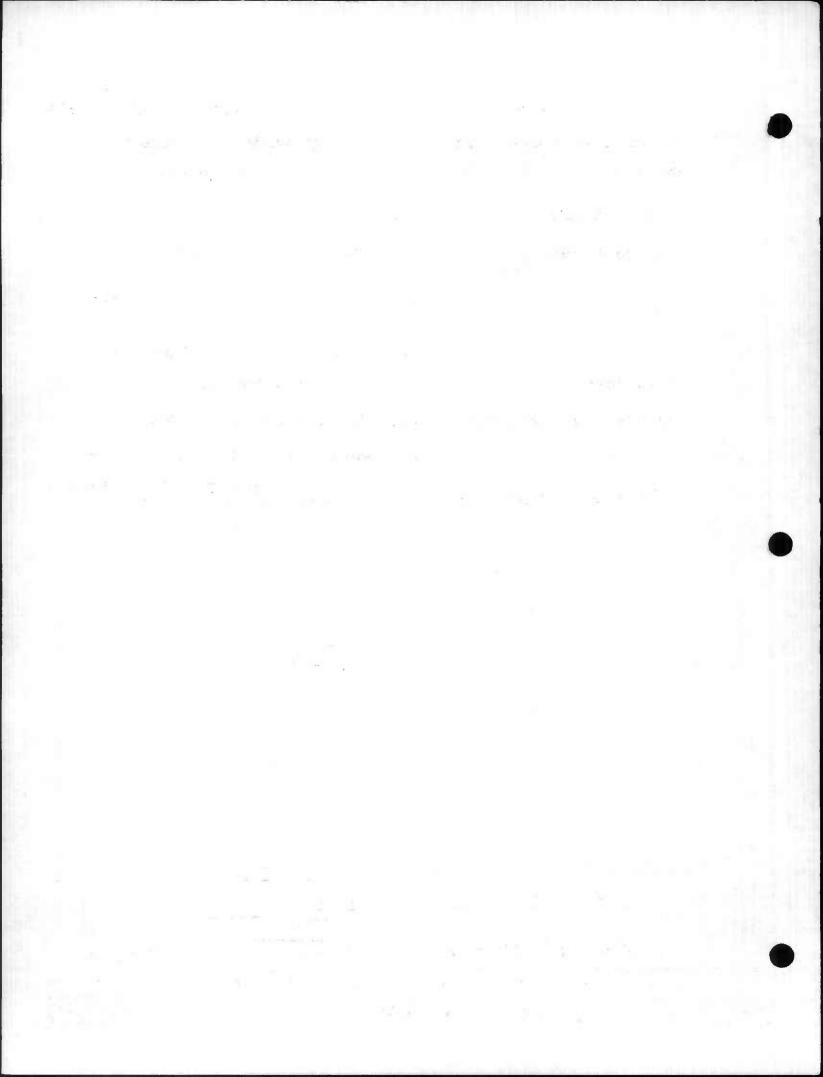


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No." 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Day **Physician** Margaret Hokanson 1998 March 16 1:30am /Medical 4b. City, Town, or Location of Deeth 4a. Facility Nema (If not institution, give street end number) 4c. County of Death **Examiner** Fairhaven Health Care Center Sykesville Carroll 7. Age (In yrs. lest birthdey) If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M &F F 220-14-5712 93 Yrs. Director Oct 21 1904 Usuei Residence of Decedent pemit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expansion must be must be once. 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Md Carroll Sykesville 1 ☐ Yes 2 No Director 10e. Straet and Number 10f. Zip Coda 10g, Citizan of What Country? 7200 Third Avenue 21784 USA Funeral 12. Was Dacedant Evar In U,S. Armed Forces? 14. Race - Amarican Indian, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yas 2 XNo If Yes, Give Yaar or Detas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specifiwh ite þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) mortgage clerk insurance 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Milton Boss Emma Schroder 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Wenzing (executor) 45 W. Main St. Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Carroll Cremation Serv. 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3-16-98 Hampstead, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licensee Parge Harglet Herbert P.O. Box 195 Sykesville, Md. 21784

23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete intervsi Between Onset and Death **Physician** /Medical Immediate Cause (Fine) disaasa or condition resulting in deeth) · Acute bronchitis or pueumania one week Examiner Due to (or es a consequence of): Physician/Medical Examiner Chronic obstructive pulmenury yeurs physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): SS signed by the et d be detached for Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown she also had type 2 diabetes and à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? coronary artery disense. page 2 s 1 Yes 2 No 1 □ Yes 2 □ No certificate or Attending Physician: funeral director. 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 250 No After this 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Neture s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner stated. 29e. Cartifier Medical (Check only one) 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) m C- un MD 3/16/98 034406 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Allam, 1645 Liberty Rd., Eldersburg, MD 21784 Richmond P. 31. Dete filed (Month, Day, Year) 32 Apgistrar's Signeture State MAR 1 8 1998 Registrar



Piease Type or Print in Black Indeiible Ink. Assure Ail Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Kuby HICKS 03 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Livingston Health Care Center Fort Washington Prince George's If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Months 1□M 2XF 136-14-1324 81 Gastonia, NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 430 Ridge Road, SE #101 20019 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 Married 1 □ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondary (0-12) Clerk Federal Govt./Vista 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) William Barber Amanda Roulware 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 430 Ridge Road, SE #101 20019 Abraham B. Hicks/husband Wash., DC 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cametery 3/23/98 4 ☐ Donetion 5 ☐ Other (Specify) Suitland, Maryland 21. Signatural Funeral Service License 22. Name and Address of Fecility Tyrone J. Young Funeral Services 719 Kennedy Street, N.W. Washington, DC 20011 Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to for a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use centribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

The law requires that the death certificate be axecuted

signed by

Deen has

certificata

Attending Physician:

al or Attending Physic s after death. If Director: After this o

Hospital 24 hours a 24 hours

filled in by

Medical

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a State

TC

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be marked once.

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai ģ Completed

the attending physician and hed for usa as the buriel-transit should be detached page 2 funeral director,

Be 10 tha

complataly To the To the To the F

Certification:

(Check only one) 29b. Signature and title of certifier

20

5 Pending investigation 8 Could not be determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year)

28b. Time of injury

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

Suite101

30. Name and address of person who completed cause of eleeth (Item 23a) (Type, Print) DR 010 00

Berwa 31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Deeth

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Cartifier

4 Homlcide

32. Registrar's Signature the dibusteer had t

State Registrar

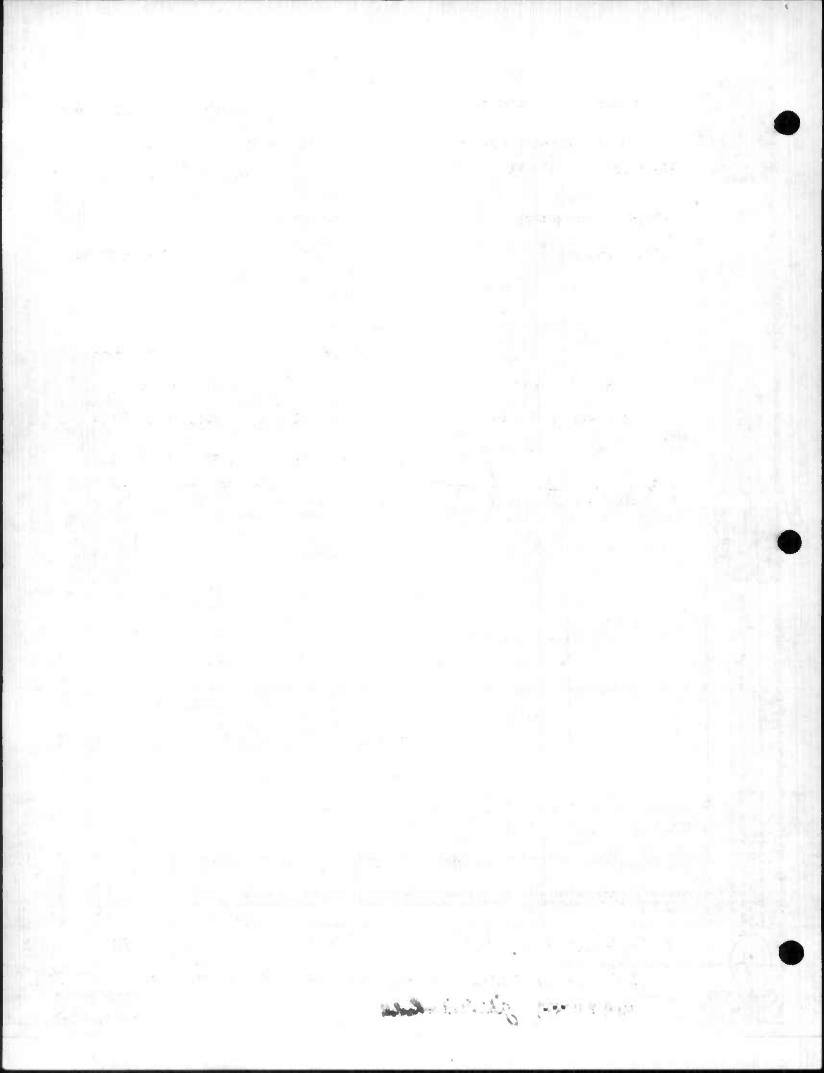
DHMH 16 Rev 6/95

29d. Date signed (Month, Dey, Year)

State of Maryland / Department of Health and Mental Hygiene

				:		Cei	rtificate d	of E	Death	7		Rag. No.	0	100/3
	П	1. Decedent's Name (First, Midd	la, Last)								2. Date of De	ath	V	3. Time of Death
Physici Medio/		Eloyce		Hacket	t						Month March	Day 1.7	Year 1998	6:45PM
Examir		4a. Facility Name (If not institution	n, give stree	et and number)				48	o. City, To	own, or L	ocation of Deat	4c. Co	ounty of Dea	
		Woodside	Nursii	no Cent	er				Sil ₃	ver (Spring	1	lontgo	merv
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. last bi	irthday)	If Under 1 Y		If Under	24 Hrs.	8. Date of Bir (Month, De	th		thpiaca (State or Fore
Director		577-01-5819	1□ M	2 KF	90	Yrs.	Months Da	ays	Hours	Min.	Aug. 3			
D		Usual Residence of Decedent									Aug	J, 190	J/ Wa	sh., D.C.
ylan	, ,	10a. Stete 10b. County	,		10c. City, Tov	vn or Lo	cation							10d. Insida City Lim
Mar F	ģ	Maryland Mon	tgome:	ry			Silv	er	Spr	ing				1 XYes 2 ☐ 1
1 284	Director	10e. Street and Number					10f. Zip Coo	de				10g. Citiza	n of What C	ountry?
A S		9101 - 2nd A	Ve						2091	n				States
n 72 hours efter death with the Maryland *natural", or items 23a or 28a-f show solical Examiner must be notified at	Funeral	11, Marital Status		Was Decedent	Evar in U.S.	ar in U.S. 13. Was Daceder			nt of Hispanic Orlgin? (Specify Cuban, Mexican, Puerto Rice					erican Indian,
Ter I	P	1 Never Married 2 Mar		Armed Forces?		1	f Yes, specify (Cuban	, Mexica	n, Puerto	Rican, etc.)		Black, Whi	
13.04	by	3 □ Widowed 4 □ Divorced		If Yes, Give	140	1 ☐ Yes 2 【No Specify:			*		St	pecify: B	lack	
tura	豆	15. Deceder			160	Dococ	tent's Lieual Oc	201100	tion			toh Kind	of Divisions	Andress.
c • 8	Completed	(Specify only highe	st grade co	mpleted)	100	16a. Decedent's Usual Oc (Give kind of work do		k done during most of working e retired)			ing	IBD. KING	of Business	rindustry
filed within Hygiens.	E C	Elementery/Secondary (0-12)		College (1-4or	5+)	Clerk								
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od ita	Be													
should be to and Mental I marked of umatic eve	L	Richar				Bertie Harley 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Co								
		19a. Informant's Name/Relations			19	b. Mailir						-		
Health Health Hem 27 I		Naomi Newma	n / Co	ousin					n PI.	. , N	.W. Was	n., D.	.C. 20	001
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 🗆 🗅 🗅 🗆 🗢	wal from State	20b. Place of cemete	of Dispo ary, cren	sition (Name o	of place)		Dete	20c. Local	tion - City or	Town, State
permit. Pages 1 enc Department of Healt Important: If Item 27 any Injury or other once.		4 Donation 5 Other (S		IVAI Irom State	Mt.	01:	ivet Ce	met	terv	13	3/21/98	Wa	ash.,	D.C.
mit.		21. Signature of Funeral Service	Licegaee	Λ		- 1	. Nama and Ad			ity				
Depa Impo any Ir		N. K. T	4	#	111						ewart			
-		23a. Part 1. Anter tha disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock of heart failure. List only one cause on each line. 4001 Benning Rd., N.E. Wash., D.C. 20019 Approximate interval Between												
		shock or heart failure. List	only one ca	ause on eech li	ne.	not ente	er the moda or	aying	, such as	cardiac	or raspiratory a	rrest,		Approximate Interval Between
Physician													Onsat and Death	
/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Failuse To Thrive										many yen		
	_	resulting in death)			Due to (or as a	conseq	uence of):							
pe #s	ine		b. —		Fa	ill	ure	I	0	Th	zine	-		
artificate be executed ing physician end e es the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying													
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artificate be executed ing physician end es the buriel-trensit	edicai	that initiated events resulting in death) Last	consequ	uence of):										
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	an		d								-			
thet the death co	Physician/	Part II. Other significant condition	nderlying cause	lerlylng cause given in Part I. 23b. Dld					d tobacco use contribute to the causa of deat					
the by th	J.			-							10	Yes 2 2	No 3∏P	robably 4 Unkno
4 60	by F											-77		, , , , ,
requires ween sign hould be											24a. Was	an autopsy	24b.	Were sutopsy findings
been s	Completed										perfo	rmed?		available prior to completion of causa
S S C	E C													of death?
cate h	ပိ										10	res 201	No	1 ☐ Yes 2 ☐ No
s certificate hes director, page 2	Be	25. Was case referred to medica examiner?							28. Plece	e of Deat	(Check only o	ne)		
5 00	ို	1 ☐ Yes 2 ☑ No	Hospi	tel: 1 ☐ tnpatie	nt 2 ER/O	utpatien	t 3□ DOA	Other	4.2 NI	ursing Ho	ma 5 Resid	dence 6	Other (Spe	cify)
ding Pi h. After ti funera		27. Manner of Death 1. Netural 5 ☐ Pendin		Ba. Dete of Inju (Month, Da)	ry (28b. 28b.	Time of	28c. t	mjury :	at ?		28d. Describe	now injury o	ccurred	
Attending or death. ector: After by the fune	ati	2 ☐ Accident invasti	gation		HE.	Injury Work? 1 Yes 2 No								
or Attended efter deat Director: I in by the	130	3 ☐ Suicide 6 ☐ Could determ		Be. Place of Inju	ury - At home, fa	arm, stre	et, factory, offi	ice			28f. Location (a	Street and N	lumber or R	ural Route Number,
s effe	Certification:	· C Homolog		building, etc	. (Specily)						City of 10	vii, State)		
Hospita 24 hours Funeral etely filled		29a. Certifier 18 Certifyin	g Physician	n: To the bast of	of my knowledge	, death	occurred at the	e time	, date an	d piace,	and due to the	cause(s) an	d menner a	stated.
Fu Fu	edicai	(Check only 2 Medicat one)	Examiner: (On the basis of and manner sta	examination an	d/or inv	estigation, in m	ny opi	nion, dea	th occurr	ed et the time,	dete and pla	ace, and due	to tha cause(s)
To the Hospital or Attending Phithin 24 hours efter death. To the Funeral Director. After the completely filled in by the funeral	X S	29b. Signature and title of certifie					29c. Llc	ense	number			29d. Data s	igned (Moni	h, Day, Year)
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		Mohamma	U A			30	- 0	nu	8611	0	WH C	1	300-	1614
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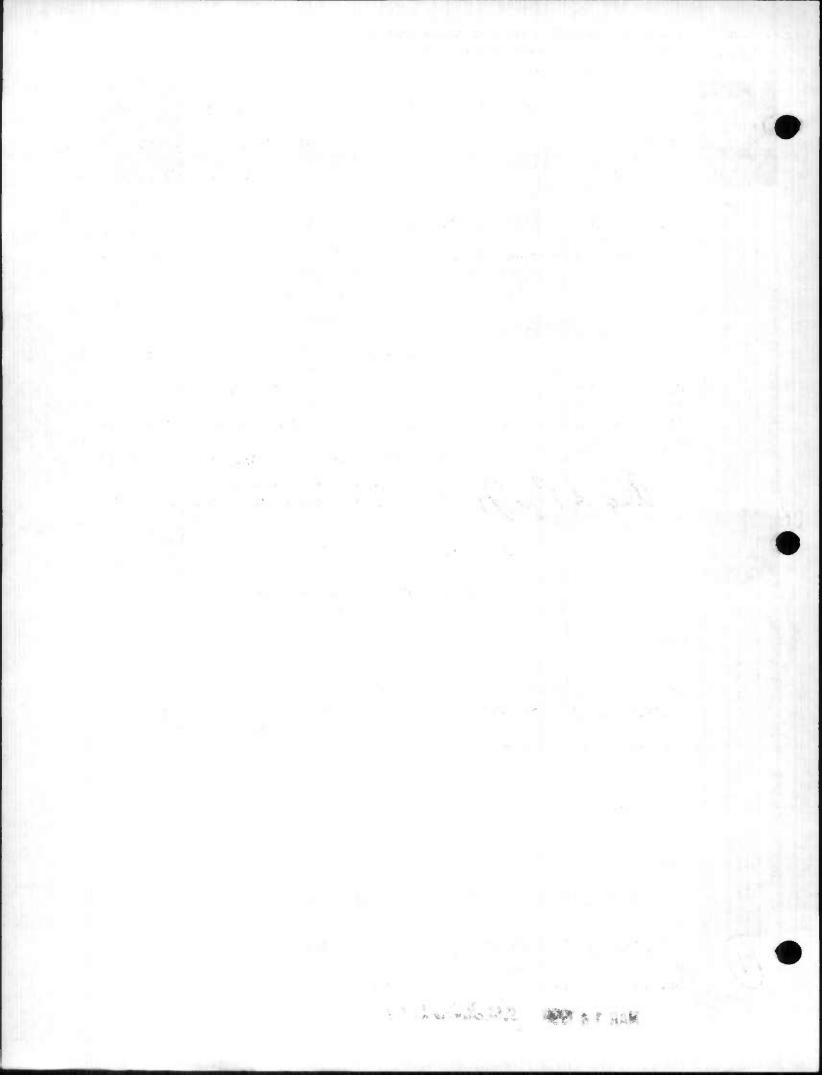
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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						Cei	tificate of	Death		Reg. No.			
П	Dharaini		1. Decedent's Nama (First, Middle, La	est)					2. Date of Do Month	eath Day	Year	3. Time of Death	
	Physici /Medi			GEORGE	E. HAW	KINS			March		998	9:51AM	
	Examir		4a. Facility Name (If not Institution, gi		4b. City, Town, o	r Location of Dea			7.7.1.1.1.				
			REGENCY HEALTH	SERVICES				ILLE	PRINC	E GEO	RCES		
	Funeral		5. Social Sacurity Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	s. 8. Data of Bi			laca (State or Foreign		
	Director		578-24-9358	1⊠M 2□F	72	Yrs.	Months Days	Hours Mi	Dec 16	ay, Year)	Wash.	,D.C.	
	D		Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·					200 20	, 1,15		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	ylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits	
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	h th	Director	10e. Street and Number			10f. Zip Code				10g. Citizen of	What Coun	try?	
	3a c		1423 New Jersey	Avenue,	N.W.		2000	1		United	Stat	es	
	deat me 3	Funerai	11. Marital Status	-1	2. Was Decadant Evar in U.S. 13. Was Decedent of H				Specify Yas or N	o- 14. Rac	e - Americ		
0	or its		1 ☐ Never Married 2 Married				irto Hican, etc.)	Bla	ck, White,	etc.			
21215-0020	72 hours efter death with the Maryland natural', or items 23a or 28s-f show cas Examinet rout be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Da	e ites: 43-45	5 '	☐ Yas 2 No	Specify:		Specif	y: Bla	ick	
20	72 ho	Completed	15. Decedent's E	ducetion		16a. Deced	ent's Usual Occu	pation	un ade la a	16b. Kind of B	usiness/Inc	dustry	
21	hin 7	Pie.	(Specify only highest gr Elementary/Secondery (0-12)	College (1	-4or 5+)	life. L	OO NOT use retin	during most of w	orking				
7	d wil	PO	12			Labor	er			Private			
P	oth of High	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	e, Maiden Surname)			
<u>a</u>	Ablut Menter rked rked	To	George Hawkins			Mary 1	Mary Dixon						
Maryland	short and a		19e. Informant's Name/Relationship	(Type, Print)		19b. Mailln	g Address (Stree	and Number or I	Rural Route Numb	ber, City or Town	State, Zip	Code)	
Σ	alth e		Eileen Ann Willia	ams /Dau	ghter	6416	Inlet 9	St. New (Carrollt	on. Md.	Md. 20784		
re,	f Heil		20a. Method of Disposition		20b. F	Piace of Dispo	sition (Name of natory or other pla		Date	20c. Location			
E	oage ent o ht: If y or		tX Buriai 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		iate		National		3/20/98	Triang1	e. Vi	iroinia	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Mod call Examiner must be notified at another.		21. Signature of Funeral Service Lice	3/20/30	11101161	, 1	rr 9 mm						
ã	Dep June Sury		b /10 0 1 3	0. () ,,,			ER S. POI					
	_		or week of	Jug		359	2617 Per	nnsylvan	ia Avenu	e, SE DO	2002		
			23a. Part1. Enter the disease, or con shock, or heert failure. List only	one cause on ea	ach line.	n. Do not ente	or the mode or dy	ing, such as cardi	ac or respiratory a	arrast,	- 1	Approximate Intervel Between Onsat and Death	
	Physician /Medical												
	Examiner		Immediate Cause (Finat disease or condition resulting in death) CONGESTIVE HEART FAILURE										
		<u></u>	,		Due to (c	or es a conseq	uence of):						
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	certificate be executed iding physician and use es the buriel-trensit	xar	Sequentially list conditions, If any, leading to Immediate										
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0	es thet the death igned by the ette be deteched for	Physician	Pert II. Other significant conditions of	23b. Did tobacco use contribute to the cause of death?									
₾	d by detec		CEREBROVASCULAI	1 🗆	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown								
Ś	The law requires thet ste hes been signed b page 2 should be dete	b		-									
0	v require been si should t	ted	Coronary Artery	Diseas	e					s en eutopsy ormed?	8VB	ere autopsy findings allabla prior to	
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>	ysici s ce direx	To	examiner? 1 ☐ Yes 2 ☒ No	Hospitei:	patient 2 🗆	ER/Outpatien	3□ DOA O	ther: Nursing	Home 5 ☐ Res	Idence 6 Ott	ner (Specifi	()	
0	g Physer this seral di		27. Manner of Death	28a. Date o	f Injury n, Day Year)	28b. Time of	28c. Inju			how injury occur			
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N N	or Attending Physician: after death. Director: After this certific I in by the funeral director,	Ific	3 Suicide 6 Could not be determined	286. Placa	of Injury - At ho	ome, farm, stre	et, factory, offica			(Street and Numi	be <i>r or Rur</i> a	l Route Number,	
ā	P P P	Certification:	4 Homicide determined							own, State)			
	to the Hospital or Attending Physician: in the Latin Lat house after death in the Funeral Director: After this certific ompletely filled in by the funeral director.		29e. Certifier 1 Certifying Pt	ysician: To the t	pest of my kno	wiedge, deeth	occurred et the t	ime, dete and plac	e, and due to the	cause(s) end m	anner es st	ated.	
	e Ho Fu jetel	edical	(Check only 2 Medical Examone)	niner: On the bas and menn	sis of examine	tion end/or Inv	estigation, in my	opinion, death occ	curred at the time,	, dete end plece,	and due to	the ceuse(s)	
	to the Hospital ithin 24 hours to the Funeral ompletely filled	Me	29b. Signature and title of certifier	,	\wedge	0	29c. Licen	se number		29d. Data signe	d (Month,	Day, Year)	
	()		* Hlory (.	un	an. y	M	D39	550		March 1	3. 19	998	
1	171		30. Name and address of person who	97	of death /Item	23e) (Tune 1							
	(')		Dr. George C. Ha				-	I anh a-	MA	20706			
	Sta	to	31. Dete filed (Month, Day, Year)		gistrar's Signa		es DIAG	, Laimam	, riu.	20/00			
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	J		MAR 1 6 799	0		- Total Ordinal							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Lest) 2. Data of Death 3. Time of Death 2:16 Month Henry Hart nn March 99 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Secours Baltimore Baltimore Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
N • C • Days Hours XIM 2□ F 246-18-8727 78 Aug.1,1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Md. Baltimore 1√Yas 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 Tioga Parkway 21215 U.S.A. 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 11. Maritai Status 1 XYes 2 No If Yes, Give WW Yaar or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 N Divorced Black. 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Coilega (1-4or 5+) Laborer Construction 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ouillie Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Lou Ann Green Niece 3004 Tioga Parkway Baltimore, Md. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Union Cem 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State 3/18 Linden, N.C. 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Address of Facility Hunt Funeral Home 21 Signature of Funeral Service Licenses 1420 34th St.S.E.Wash.D.C.20020 23a. Part1. Entar the diseasa, or complications that ceused the daath. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Betw Onset and Daath Immediate Cause (Final tachy cardia disease or condition resulting in death) atherosclerosis eneralized (Due to (or as a donsequence of): Septicemia Due to (or as a consequence of): Chronic renal Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Bleeding gastriculcer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 Yas 2 No

Physician /Medical **Examiner**

the buriel-transit

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

this certificate

After

death.

To the Hospital within 24 hours e

s efter death

completely filled in by the funeral

Be Completed by Physician/Medical Examiner

2

Certification:

Medical

Physician

/Medical

Examiner

10a State

Director

Completed by Funeral

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-1 shov traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death 1 Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumetic event, the Medical Experimental 2006.

the Maryland

with

21215-0020

Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last

gastrointestinal Gout

26. Place of Death (Check only ona)

1□ Yes 200 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending Investigation

Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Tima of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Othar: 4 Nursing Home 5 Residance 6 Othar (Specify) 28d. Describe how injury occurred

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Naturai

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifiar

MAR 1.6

6 Could not be determined

29c. Licansa numbar

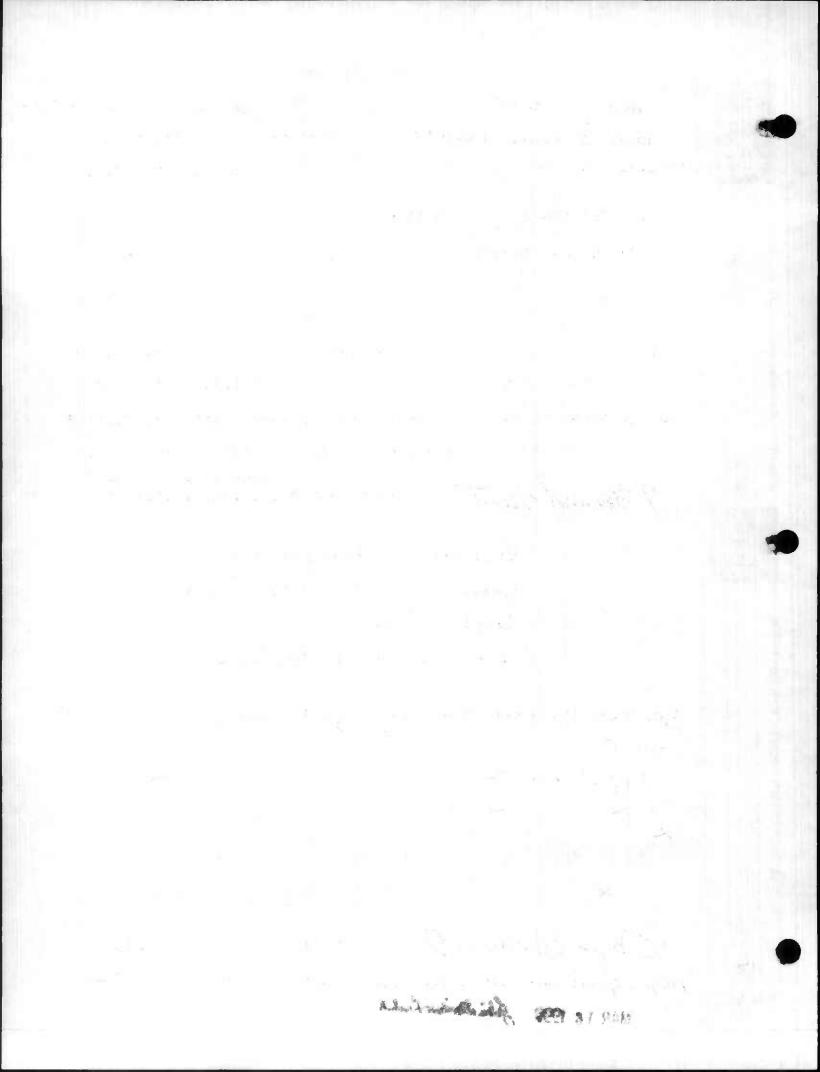
29d. Data signad (Month, Day, Yaar)

who complated causa of daath (Item 23a) (Type, Print) 30. Nama and addrass of person

MOGES Geble MariaM: 4660 Wilkens Are. Balto md 21229
31. Date Filed (Month, Day, Yaar) 32. Degistras Signatura

State Registrar





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month DANNY Cornelius Henderson 12:35AM MARCH /Medical 4e. Facility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL Clinton Prince Georges If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Oct. 1, 1962 If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) **Funeral** Days Months 1⊠M 2□ F 35 Yrs Director 218-90-8437 Wash.D.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ral', or items 23s or 28s-f show Examiner must be notified at 10d. Insida City Limits Md. Prince Georges Upper Marlboro Director Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 13139 20772 Ripon Place U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Wes Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Bleck, White, etc. 11. Maritel Stetus 1 Nevar Merried 2 Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Yeer or Datas: Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 🛣 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Hygiene. other than "nature ent, the Wedical E 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Private Ind. Elamantary/Secondary (0-12) Coilege (1-4or 5+) .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, its Mail Clerk Suggs Transportaton 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Henderson James Almeta LeGrand 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lisa C.Henderson Wife 13139 Ripon Pl. Upper Marlboro, Md. 20772 20b. Plece of Disposition (Name of cematery, cremetory or other place)
Way of CRoss Cem. 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If eny Injury or 3 - 14Largo, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funarel Service Licansae 22. Name end Address of Facility Hunt Funeral Home Bemara 1420 34th St.S.E.Wash.D.C.20020 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one ceuse on each line. Approximete Intervei Between Onset and Deeth **Physician** Septicemin (fungal) /Medical Immediate Cause (Final New. diseese or condition resulting in deeth) Examiner Due to (or es e consequence of):

intesting obstrution Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Ihat initieted events rasulting in deeth) Lest P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): the Pert II. Other significent conditions contributing to deeth but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertensi Records, þ 24b. Wera eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? certificate 1 □ Yes 2 □ No. Division of Vital or Attending Physician: 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To nours after death.

neral Director: After this filled in by the funeral di this 27. Menner of Deeth 1 Natural 28a. Date of injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Thomicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner stated. 29a, Certifier (Check only one) 29b. Signatura and title of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) D25640 9 March 98 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 1328 Southern Ave . # 202 Washington DC. 20032 31. Date filed (Month, Day, Yeer) State Registrar MAR 16 1998

12 e weather was a second

State of Maryland / Department of Health and Mental Hygiene

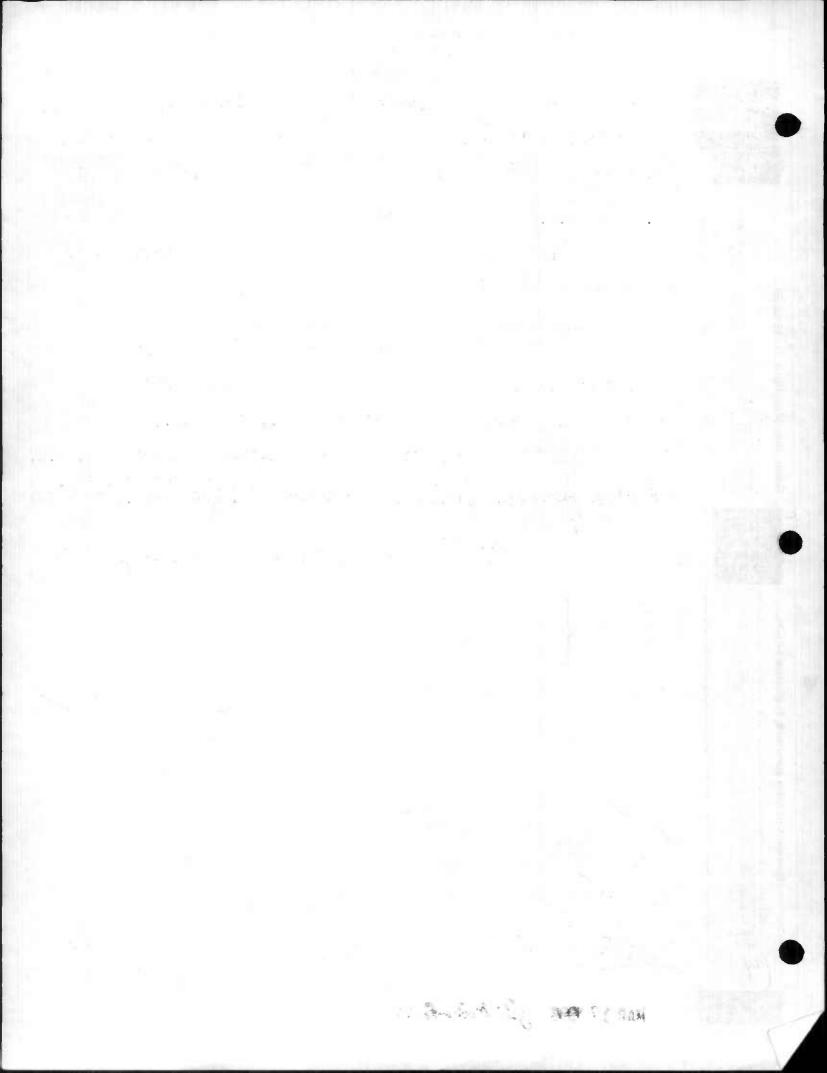
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month MARCH VIRGIE HARGRAVE 4:35AM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRINCE GEORGE®S MEDICAL CENTER CHEVERLY PRINCE GEORGES 7. Age (In yrs. last birthdey) If Under 1 Year Months Deys if Under 24 Hrs. 5. Social Security Number 9. Birthpiece (State or Foreign Funerai 1 M 2 XF FLORIDA 50 Yrs. 577-64-8807 Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Director P.G. 1 X Yes 2 No MD. LANDOVER 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 7410 GOODLAND DRIVE items 23a UNITED STATES 20785 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Û No if Yes, Give Yeer or Detes: Reca - American Indien, Bieck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiena.
Int: If Item 27 Is marked other than "natural", or Ite 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: BLACK 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) MENTAL HEALTH TECH GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be LEMUEL STEPHENS MATILDA McCOY 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if Item 27 is eny injury or other trau 3048 PINEVIEW CT., NE WASH., DC 20018 CALVIN CADE BROTHER 20e. Method of Disposition

1 □ Buriel 2 □ Cremation 3 □ Removel from State 20b. Pieca of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete GLENWOOD CEMETERY 3 + 18 - 98WASHINGTON, D.C. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service 22. Neme end Address of Fecility CAPITOL MORTUARY, INC. 1425 MARYLAND AVE., NE WASH., DC 20002 complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete intervei Between Onset and Deeth **Physician** i adenolarcinume of Lung /Medical Immediete Ceuse (Finai diseese or condition resulting in death) Examiner Examiner Hospital or Attanding Physician: The law requiras that the death certificate be executed 24 hours after death.

24 hours after doeath.

24 hours after doeath.

25 hours after this certificate has been signed by the attending physician and attanded to the control of the contro Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequenca of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 Dipatient Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28c. injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signet nd little of certifle 29c. License numbe ne and edo ess of person who completed cause of deeth (Item 23e) (Type, Print) IQUAKU 31. Dete filed (Month, Dey, Year) 33. Registrar's Signeture State A divolen Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 3. Time of Death m 2. Dete of Death Month MARY HOLMES MARCH 1998 12 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death PRINCE GEORGES PRINCE GEORGES HUSPITAL CENTER CHEVERLY If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1□ M 21 F Months Deys Yrs. 428-14-4711 Sept 19, 1921Mississippi 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Capitol Heights 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7203 Giddings Drive 20743 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Specify: Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yrs. Accountant Food & Drug Administratio 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Steve Caldwell Mary Ellen Caldwell 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Farris Holmes-Husband 7203 Giddings Drive, Capitol Hgts., MD 20743 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Mem. 3-18 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 4217 9th Street N.W. Washington, DC 20011 23a. P tf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. immediate Cause (Finel , HYPERTENSIVE ARTORIOSCUBRETIC CARDIOVASCULAR DISTOSE disease or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the ceuse(s) end manner stated.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year) MARCH 17, 1998

Physician /Medical Examiner

permit. Paga Department of Important: If any foliury or

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Нета 23a

Pagas 1 and 2 should be filed within 72 hours aftarnant of Haalth and Mental Hygiana. Int: If Item 27 Is marked other than "natural", or Ite

Baltimore, Maryland 21215-0020

MD

the Medical Examiner must be nothed at

Director

Funeral

by

Completed

the Maryland

that the death certificate be axecuted physician and ts tha burial-trans

P.O. Box 68760,

Records,

of Vital

Division

Physician/Medical Examiner þ Completed page 2 s cartificata To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica completaly filled in by the funaral director, Be P Certification:

10 Registrar

State

Medical

31. Date filed (Month, Day, Year) MAR 17 19

MARIO F.

29b. Signature and title of certified

30. Name and address of person who

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending Investigation

6 Could not be determined

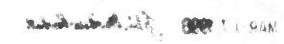
GOLLE

HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DME

(item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11, 1998 IRICK MARCH 1:23pm /Medical 4a. Facility Nama (If not institution, giva straet end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Malcom Grove Hospital, Andrews AFB Prince George's Camp Springs If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year)

July 21, 5. Social Security Number If Undar 1 Yaar Birthplace (State or Foraign Country) 7. Age (In yrs. lest birthday) **Funeral** 1X M 2 □ F Days Yrs. Director 244-68-8589 54 NC Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumstic event, the Wadical Examinet must be notified at Director 1 Yes 2 No Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 3705 Crystal Lane United States 12. Was Decedent Ever in U,S.

Armed Forces?

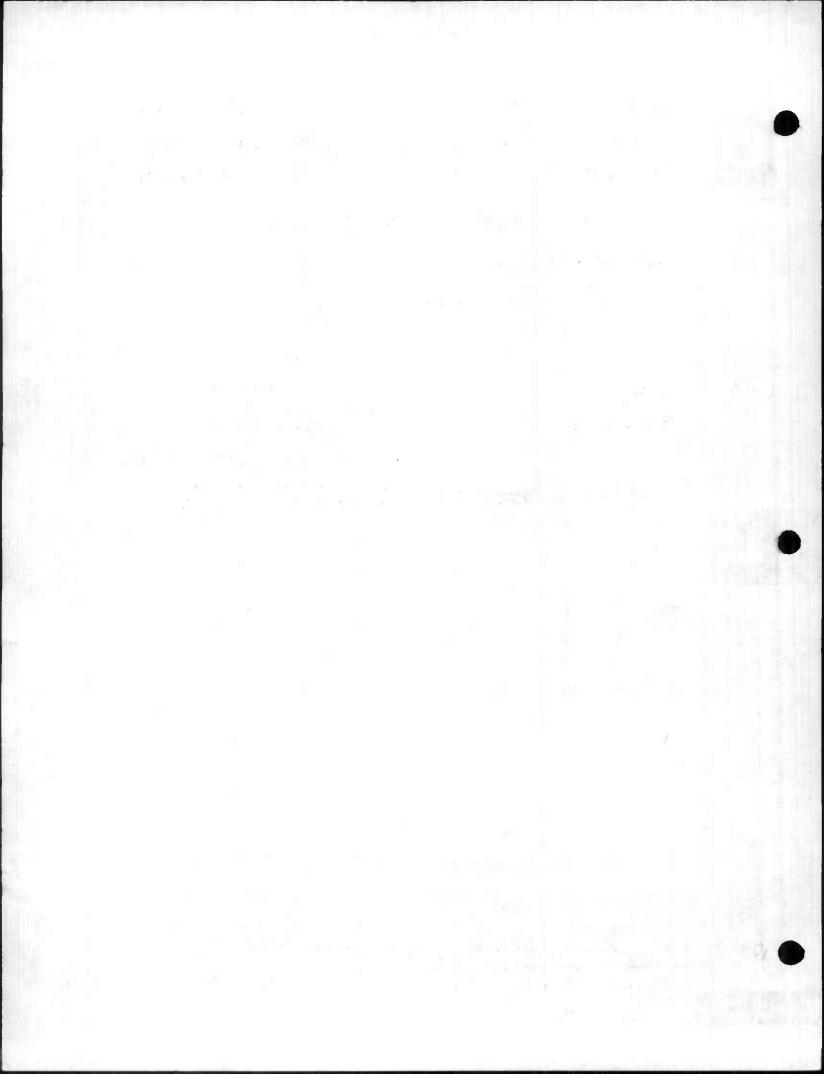
H⊟Yas 2 □ No

If Yes, Give

Year or Datas: 1967–74 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: Black p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede complated) nd Mental Hygiene. merked other than Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Analyst Federal Government permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy important: If Item 27 is merked othe any lolly or other traumatic event, page. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Roosevelt Dee Marie Irick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) <u> Sandra Irick - Wife</u> 3705 Crystal Lane, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Cemetery 3/20/98 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility R. N. Horton Co. Morticians, Inc. Approximate Interval Between Onset and Death **Physician** cardiac /Medical immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): Box 68760. the 98 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Division of Vital Records. þ page 2 should 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? certificate TE Yas 2 □ No 1 Yas 2K No or Attending Physician: director. Be 25. Was cese referred to medicei 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To After this in by the funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicida 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) ABBAS SHAHLHA 31. Date filed (Month, Dey, Year) Registrar's Signature State Jula Savidson

Registrar

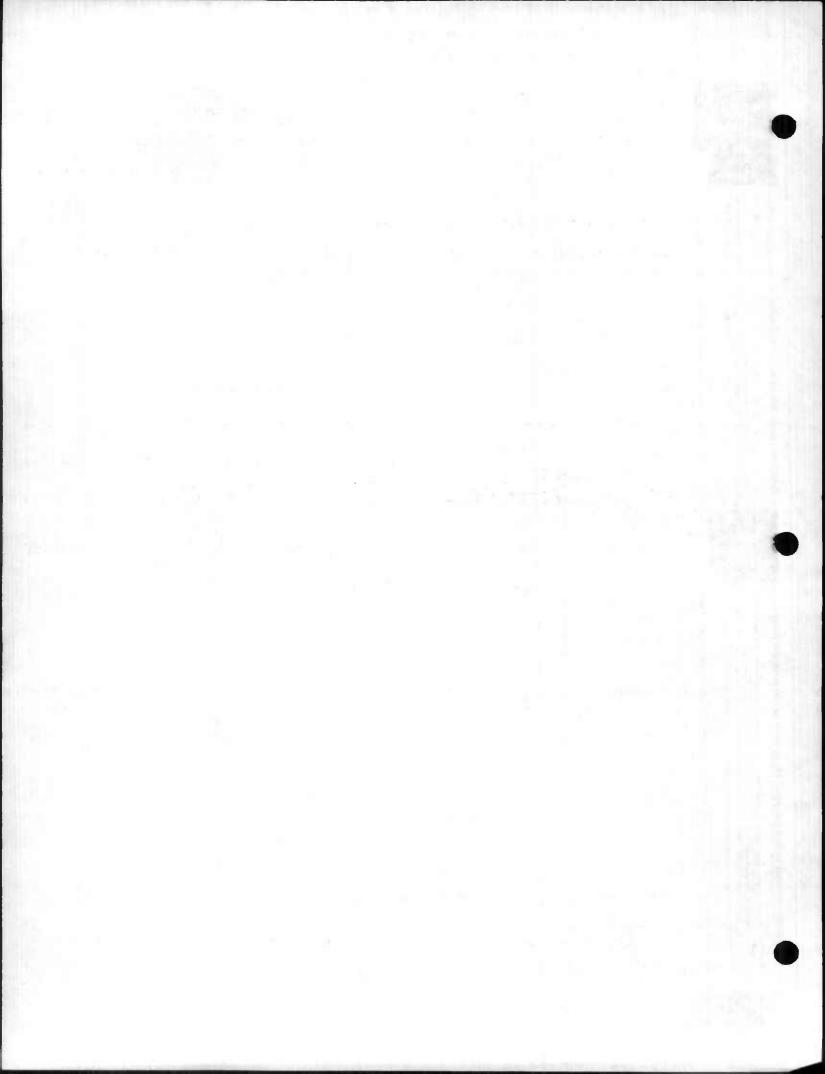


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Kose 1998 15, 1998 4c. County of Deeth /Medical MARCH 4a. Fecliity Name (if not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. lest birthday) **Funeral** Deys 1□ M 2♥ F 70 Yrs. 578-48-5526 Director July 6, 1927 Usuei Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic avent, the Madical Examiner roughly an optimed at 1X Yes 2 □ No Maryland | Prince Georges Director Hyattsville 10f. Zio Code 10g. Citizen of What Country? 7333 New Hampshire Avenue #206 20783 United States permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items; 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Merifel Stetus 1X Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Mark Jones, Sr. Catherine McCoy 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lois Ward (Friend) 635 Gallatin Street, N.W., Washington, D.C. 20011 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removel from Stete 3/21/98 Brentwood, Maryland 4 ☐ Donetion / 5 ☐ Other (Specify) Ft. Lincoln Cemetery 22. Name end Address of Fecility
McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012 Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failule. List only one cause on each line. Physician MYOCARIAL INFARCTION /Medical Immediate Cause (Final disease or condition resulting in death) UNKNOWN Examiner Due to (or es e consequenca of):

NAMY ARTEM DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760. physician Physician/Medical å Due to (or es e consequence of): 1 9 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? RENAL END STACE 1 Yee 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certifical. 25. Wes case referred to medicel Be 26. Placa of Deeth (Check only one) Hospitel: 1 Inpatienf 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 27. Menner of Deeth Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Within 2 To the F 29d. Dete signed (Month, Dey, Year)

MARCH 16, 1996 29b. Signard reyand title of certifier 29c. License number 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10 WASHINGTON ADVENTIST MOSPITAL MD

State Registrar 20 1998 Figure Signature



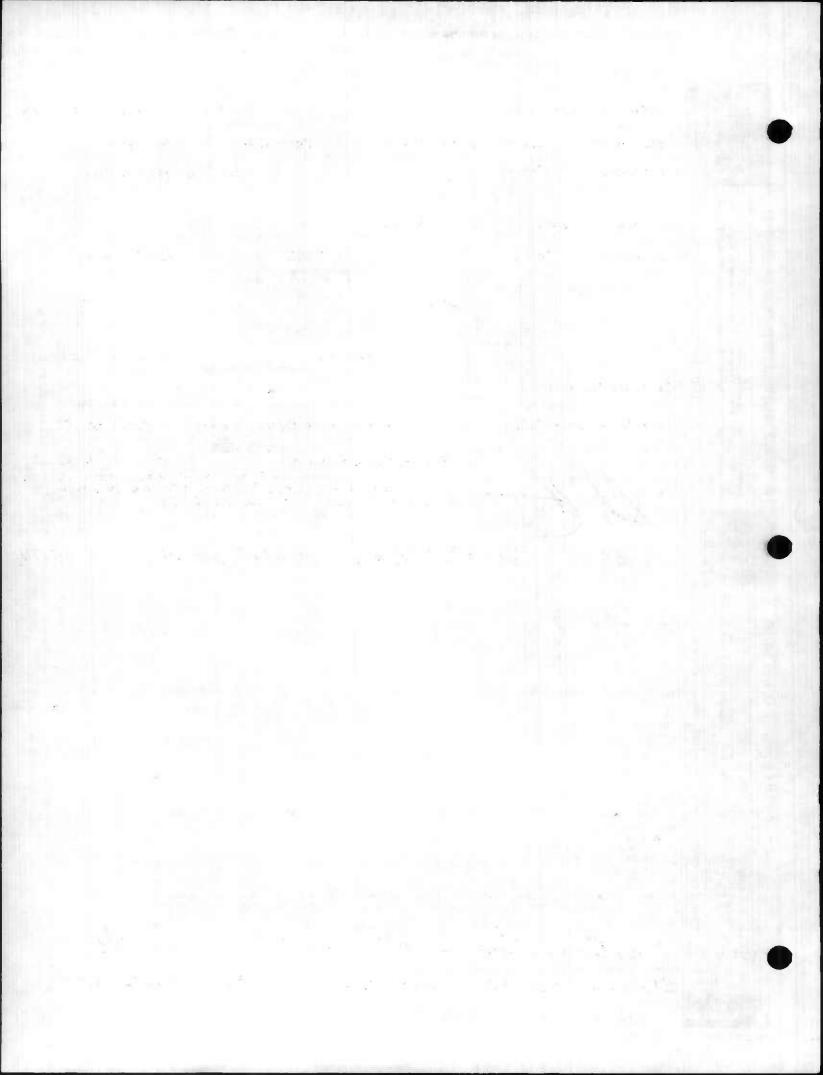
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** Norval E. Jones 15, 1998 11:20 PM March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys Yrs. 486-20-9583 Director Dec. 10, 1922 Missouri Usuel Residence of Decedent the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2 Hitching Post Court 20852 United States pernit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Menice Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give Yeer or Dates: WWII 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry during most of working Elementary/Secondery (0-12) College (1-4or 5+) Accountant Accounting Firm 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Clarence W. Jones Grace M. Thompson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Virginia A. Jones/Wife 2 Hitching Post Court, Rockville, Maryland 20852 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) March 19, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility Robert A. 21. Signature of Funbral Service License Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01126 be, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. near failure Approximete Interval Between Onset end Death Physician Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical MULTIF OR ME · GLIDBLASTOMA Examiner Examine The law requires that the death certificate be executed physician end the burial-transit Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): attending ph for use es t signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown by 24e. Wes an eutopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of deeth? cartificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: Aftar 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident ofter deatl Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hou. the Funeral Directory 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated. Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner stelled. 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number 15+1 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MONTROSE RD, ROCKVILLE 6121 LIPSON STEVEN 31. Dete filed (Month, Day, Yeer) Registrar's Signeture 18 1998

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Death **Physician** 0860 A.M. Fonda Juanita Jackson ARCI /Medical 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Dete of Birth (Month, Day, Year) Country)
April 18,1950 Maryland If Undar 1 Year If Undar 24 Hrs.

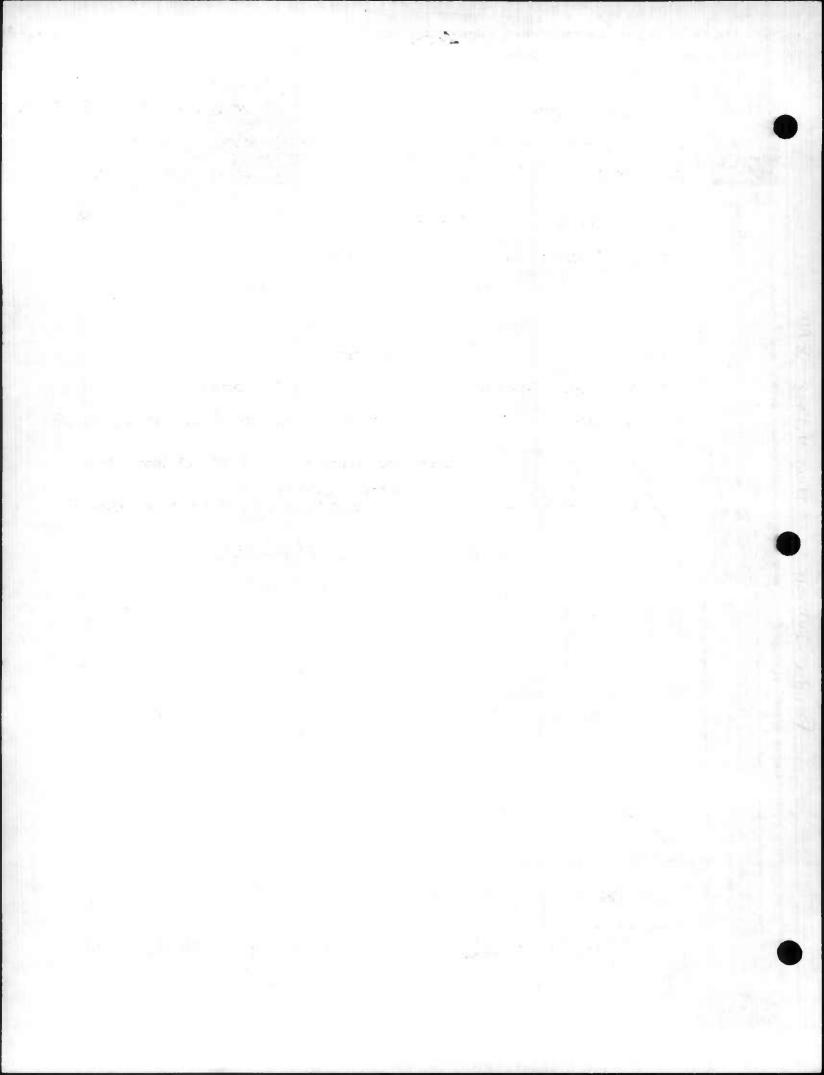
Months Days Hours Min. 5. Social Sacurity Number 7. Aga (in yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funerai** 1□M 2K F 220-52-4861 47 Yrs Director Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner must be notified at Director ty□ Yas 2□ No Aberdeen Harford MD 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 601 Cornell Street, Apt. #221 USA 21001 Funeral 12. Wes Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Giva Yaar or Detes: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 X Never Married 2 ☐ Married Specify: BLACK "naturel", or 1 ☐ Yas 2 ☐ No Specify: Completed by 3 ☐ Widowad 4 ☐ Divorced traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry nd Mental Hygiene. marked other than Elamantary/Secondery (0-12) Collaga (1-4or 5+) 12+2 secretary clerical 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 end 2 should be 1 nent of Health end Mental I Frederick Douglas Jackson Pauline Norman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pauline Norman 601 Cornell Street, apt.#221,Aberdden, Md.21001 if item 27 or other tr 20b. Piace of Disposition (Nema of cemetery, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramovai from Stata Department 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemeterv 3/9/98 Baltimore, Md. 21. Signature of Funeral Service Uce 22. Nama and Address of Fecility Beard Funeral Home Part Enter tha disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast,

Approxime Approximete Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in death) Examiner Examiner TO Veryous the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Cause (Disease or injury that initieted avants resulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consaquanca of) Part it. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. ate hes been signed by the a page 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ yo, 3 ☐ Probably 4 ☐ Unknown Records, 2 Completed 24a. Was en eutopsy partormed? Ware eutopsy findings aveileble prior to completion of causa of death? 1 ☐ Yas 2 ☐ No this certificate 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: director. Be 25. Was casa raferred to medical 26. Placa of Daath (Check only ona) axaminar? 220 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Tima of 28d. Dascribe how injury occurrad 28c. Injury at Work? After Neturel 5 Pending invastigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 3 Suicida 6 Could not be 28a. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 T Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred et tha time, date end piece, and dua to the ceuse(s) and menner es stated.

2 Medical Examiner: On tha basis of examinetion and/or investigation, in my opinion, death occurred at the tima, date end pieca, and dua to the cause(s) and mannar statad. Medicai 29a. Certifia: completely 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Date signed (Month, Day, Year) 31. Date filed (Monti State Registrar

DHMH 16 Bev 6/95

Jackson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mi	ai yiariu /		tificate of	Death	wentai ny	Reg. No.	8	0085	
	Dharia		1. Decadent's Name (First, Middle, La	ist)					2. Date of D		Vees	3. Tima of Death	
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yla		To	George I. E	George I. Bryant Co									
ar			19a. informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street	and Number or R	Rural Route Number, City or Town, State, Zip Code)				
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	Ho Fur Pterly	edicai	(Check only one) Madical Exam	iner: On the basis of and manner sta	examination ar	nd/or invas	stigation, in my or	pinlon, death occu	rred at the time,	date and place,	and dua to	the cause(s)	
	To the To the comple	Me	29b. Signature and title of certifier				29c. Licanse	a number		29d. Date signed	d (Month, D	Day, Year)	
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	10/	-	30. Name and address of person who	completed cause of de	ath (item 23a)	(Type Pri			*	0/10	1-	4	
1			Rakesk Arora,					Suite 22	2, Bowi	e, Marvl	and	20715	
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Baitimo	permit. Pages Department of Important: If th any injury or o		1 \(\text{Burlel 2 \(\text{Cremation 3 \(\text{Removal from State} \)} \) 4 \(\text{Donation 5 \(\text{Other (Specify)} \)} \) 21. Signature of Funeral Service Licansee 22. Name end Address of Facility 3/23/98 Clinton 23. Name end Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover, Mar									
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OI VIEW	the Hospital or Attending Physician: The lew lim 24 hours after death. The Funeral Director: After this certificate has impletely filled in by the funeral director, page 2	To Be	examinar Other	Death (Check only of Home 5 Resident 28d. Describe in	na)							
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	il Certification:	2 Accident investigation 3 Sulcide 4 Homlcida Sulcide 5 Homlcide 5 H	City or Tow	vn, Stete)	or Rural Route Number,						
	To the Hos	Medicai	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth ocone) 29b. Signeture end title of certifier 29c. License number	curred at the time,	causa(s) and manr data end place, and 29d. Dete signed (d due to the cause(s) (Month, Dey, Yeer)						
	(6)		30. Nama and addrass of person who completed caysa of daeth (Itary 23a) (Type/Pint) CR - DPINDER	SINGH	e) 716	1 -						

DHMH 16 Rev 6/95

State Registrar 31. Data tiled (Month, Day, Year)
MAR 1 9 1998

TAMMY LORINTA JONES

State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 2. Dete of Deeth Month

Physician /Medical Examiner

Funeral

Director the Meryland 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Moulcal Examiner must be notified at filed within 72 hours efter Hygiene. ther than "naturel", or Item permit. Peges 1 end 2 should be f Department of Health end Mental I Important: If Item 27 is marked of any injury or other treumatic eve

Baltimore, Maryland 21215-0020

Physiclan /Medical Examiner

buriel-transit and P.O. Box 68760, ettending physiclan for use es the burie 8 signed by the e Records, Division of Vital

Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, § To the Hospital or within 24 hours effer To the Funeral Director of the Funera State

1. Decedent's Name (First, Middle, Last) 3. Time of Death Elsie Mozel March 11, 1998 1:50 am 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Magnolia Center Prince George's Lanham If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, 5. Social Security Number Birthpiece (State or Foreign Country) 7. Aga (In yrs. lest birthdey) Deys 1 ☐ M 2 🂢 F 577-07-8514 91 Yrs Feb. 8, 1907 Virginia Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Maryland Prince George's Hvattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5709 37th Avenue 20782 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armad Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bieck, Whita, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Switchboard Wirer Western Electric 17, Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be James Edward Herrel1 Lena Bell Baker 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edith Thompson - Attorney 8038 Ashford Boulevard, Laurel, Maryland 20707 20b. Piece of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 03/16/98 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Francis Gasch's Sons Funeral Home, P.A. ella 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one ceuse on each line. Approximete Intervel Betw Immediete Ceuse (Finai myocordia (inferction Sudden disease or condition resulting in death) Due to (or es a consequence of) Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Atheroschrotic vascular disease; serile 1 Yes 2 No 3 Probably 4 Unknown Completed by denentia, cerchovascular accident; recurent 24b. Ware autopsy findings evalleble prior to complation of cause of deeth? 24a. Wes en eutopsy performed? aspication 25. Wes cest referred to 1 Yes 1 ☐ Yes 2 ☐ No Be 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Thomicide Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner steted. 29b. Sign d title of certific 29c. License numbar 29d. Dete signed (Month, Day, Year) 30. Name end eddress of parson who completed cause of deeth (Item 23a) (Type, Print) Peter M. Schissler, M.D. 7500 Greenway Center Drive, #430, Greenbelt, MD 20770

DHMH 16 Ray 6/95

Registrar

31. Dete filed (Month, Dey, Yeer)

MAR 16 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month CLINTON JONES 1998 Morch 16 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 10 M 2□ F 241-20-1172 North Carolina Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21207-5830 #9 King James Cir. USA 12. Was Decedent Ever in U,S. Armed Forces? ► LYes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Penn Mar 12 Truck Driver Truck Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Jones Sally Cook 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #9 King James Circle Baltimore, Maryland 21207-5830 19a. Informant's Name/Relationship (Type, Print) Stella M. Jones (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Swiai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forrest 3-23-98 Owings Mills, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6234 Third St. NW.Wash. DC. 20011 Tri-State Funeral Service, Inc. Parl. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediete Ceuse (Final disease or condition resulting in death) Due to (or es a consequence of): OMODIC Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown End Stage Renal Disease 24b. Were autopsy findings evailable prior to 24a. Was an autopsy Diabetes Mellitus completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

Physician /Medical **Examiner**

Examiner

Completed by Physician/Medical

Certification: To Be

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

r than "natural", or items 23s

death with the Maryland to or 28a-f show

filed within 72 hours after

Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ury or other traumatic event, the Man

permit. Pege Depertment of Important: If any Injury or

Baltimore, Maryland 21215-0020

inding physician end use es the bunel-transit The law requires that the death certificate be executed page 2 should Director: After death.

Hospital or Attending filled in by To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by

Medical

State Registrar

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZNNo 1. Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) and menner es steted.

| Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and menner stated. 29a. Certifier (Check only one)

28. Place of Deeth (Check only one)

29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Dey, Year)

104176435C9205 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

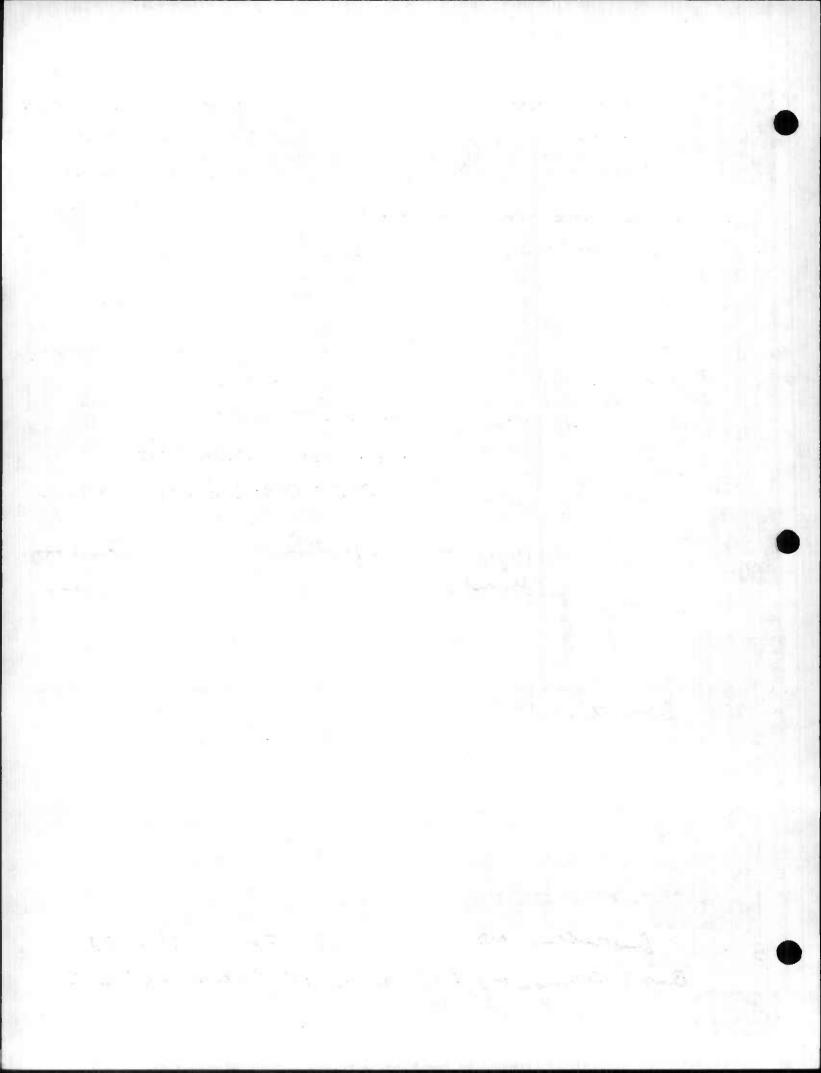
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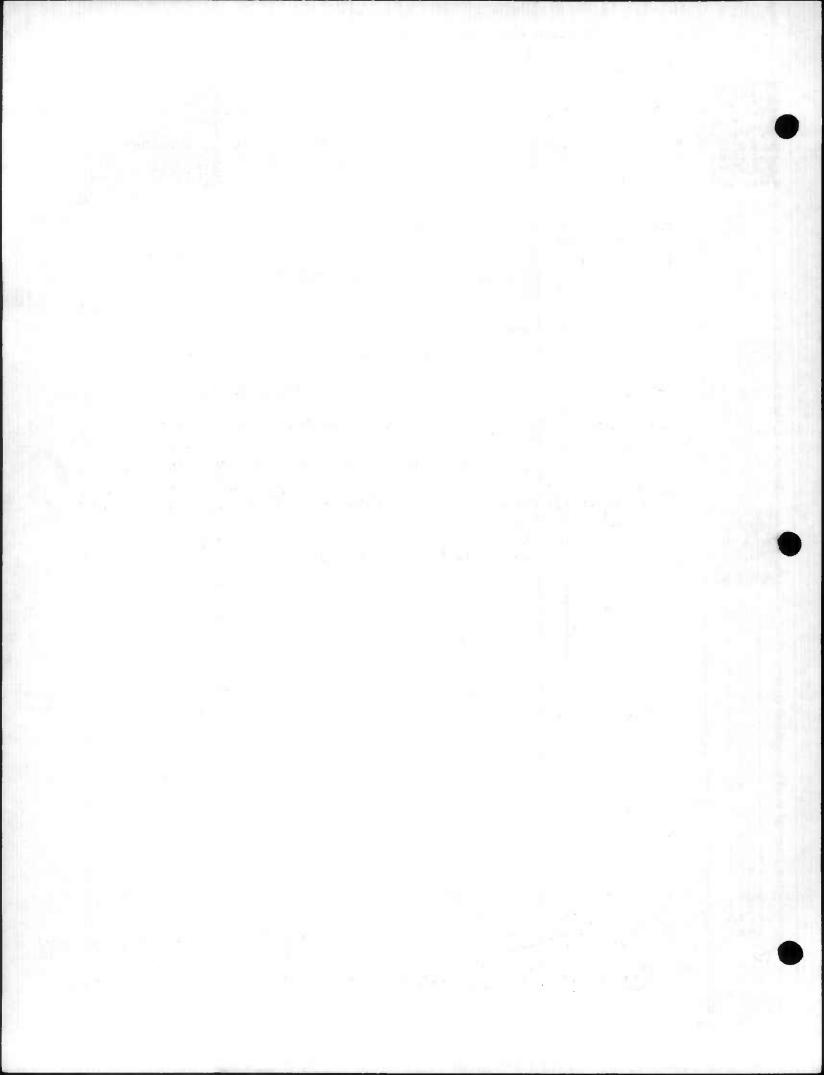
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Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3 ₩ Widowed	ied 2 Married	12. Was Deceder Armed Force: 1 Yes 25 If Yes, Give Year or Detes	No	1	13. Was Decedent of Hispenic Origin? (If Yes, specify Cuben, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:			No-	Black, W	merican Indi /hite, etc.	en,	
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State of Maryland / Department of Health and Mental Hygiene

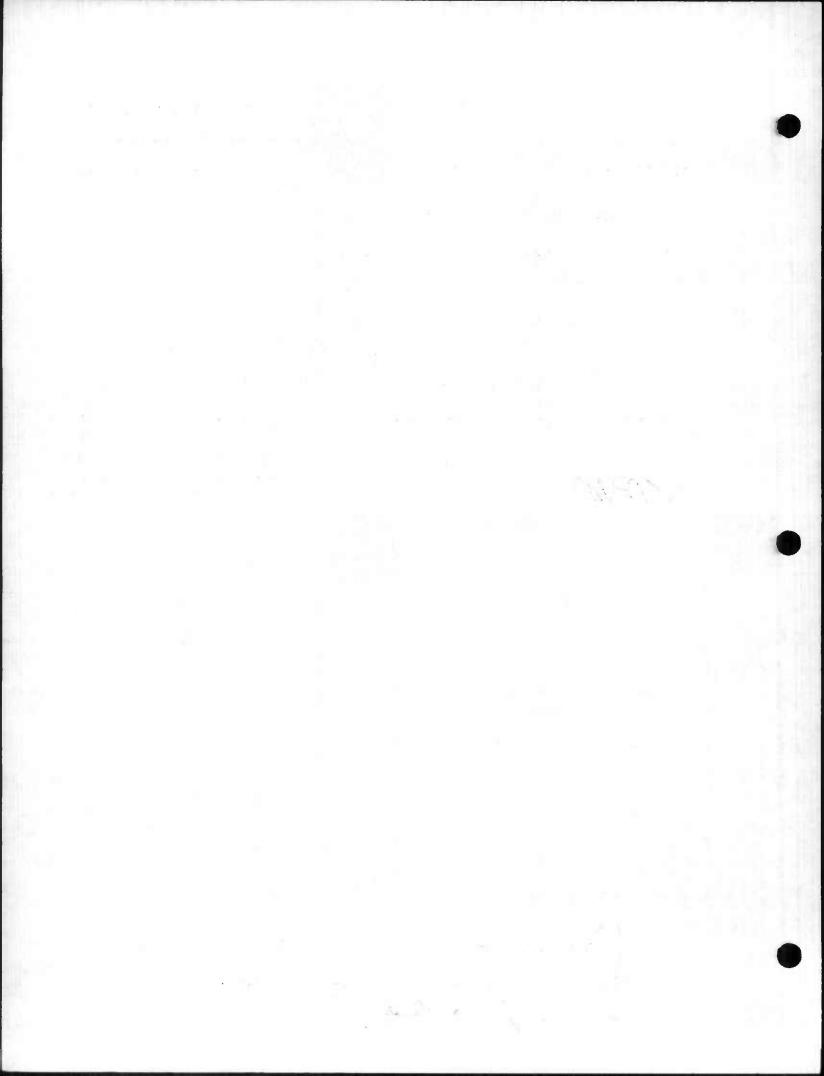
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Ba	permit. Peges 1 end 2 Department of Health Important: If Item 27 li eny injury or other tre					-		-		Funeral	Home,	Inc.		
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<u>></u>	or Att	Certification:	4 Homicide datarmin	ed 28a. Place of Inj	ury - At homa c. <i>(Specify)</i>	, farm, stra	at, factory, o	office		28f. Location (S City or Town		er or Aura	Routa Number,	
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\		ŀ	30. Name and eddrass of person w	no completed cause of d	laath (Itam_23	a) (Type, F	Print)				0	1.7	3,1998 Ne.	
			KMITE	pccia hi	2 9	707	Mal	W	- Out	IN D	. 160	Carl	le.	
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Month Veer RUTH MAE KALTRIDER 7:20 AM 1998 MARCH 12, /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LONG VIEW NURSING HOME MANCHESTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) CARROLL 5. Social Security Numbar Birthplace (State or Foreign Country) **Funeral** 1 M 20 F 94 Yrs. 219-20-0219 2/13/1904 Director MARYLAND Usual Rasidence of Decedent 10a State 10b. County 10c. City. Town or Location 10d, fnside City Limits 28a-f show event, the Medical Examiner must be notified at MD. CARROLL 1 ☐ Yes 2 ☐ No TANEYTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 4317 OLD TANEYTOWN RD. Items 23a 21787 USA. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. e filed within 72 hours after de il Hygiene. other than "naturel", or Item 1 ☐ Yaa 2 ☒ No If Yas, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKING 8 marked other 17. Fathar'a Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be h end Mental h Peges 1 and 2 should be TOLLY O. BERWAGER KATHERINE FROCK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth el important: If item 27 is any injury or other trea once. SHIRLEY E. MELLEMA-DAUGHTER 269 E. MAIN ST., WESTMINSTER, MD. 21157 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Ramoval from Stata ST. MARY'S CEMETERY 3/14/98 SILVER RUN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility FLETCHER FUNERAL HOME 21. Signature of Furnial Service Licenses 254 E. MAIN ST., WESTMINSTER, MD. Part - Enter the diagram, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fulfiller. List only one cause on each line. Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Cancer ex: cien Years Examine Due to (or as a consequence of); Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the buriel-Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should 24b. Were autopsy findinga available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate hes birector, page 2 s 1 Tes 2 No 1 ☐ Yea 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica stely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 28. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide An 24 hours. The Funeral Dire Medical 29a. Certifier t Certifying Phyaicfan: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examíner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and certified 29d. Date signed (Month, Day, Year) 29c. License number S 33316 9.5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stever Frater 2111 Havon Phe Howers (w) 31674 32 Aggistrants Signature 31. Date filed (Month, Day, Year) State MAR 16 1998 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8

			(ertificate	of Death	R	leg. No.	10072		
	1. Decedent's Neme (First, Middle, La	st)				2. Dete of Deeth		3. Time of Death		
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/Medical Examiner	4e Facility Neme (If not institution, giv	e street end number)			4b. City, Town, or L	ocation of Deeth				
- Examiner	Saint Joseph	Medical	Center		Tows	n	E	altimore		
Funeral	Sociel Security Number 6. S		e (In yrs. lest birtho	Months D	Year If Under 24 Hrs. Heys Hours Min.	8. Dete of Birth (Month, Dey	Year)	Birthplace (State or Foreign Country)		
Director	219-18-7890	X M 2□ F	72 Yr	S. MOTATIO	Note that	Mar. 29		Maryland		
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the Marylar 28a-f show notfled a	Maryland Harfor	rd	Ede	Jewood 10f. Zip Co	udo		10g. Citizen of W	**		
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a 23a must	2410 Sycamore Lane	12. Wes Decedent I	Ever in 11 S	13 Was Deceden	21040	ecify Ves or No-	USA 14 Bace	a - Americen Indian,		
Remains Income	1 Never Merried 2 Married	Armed Forces?		If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexicen, Puerto	Ricen, etc.)	Blec	k, White, etc.		
020 urs aft aff. or	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐	No Specify:		Specify	White		
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hygiene. The art Is and Mertal Hygiene. other traumatic event, the Med sal Evantice must be notified at To Be Completed by Funeral Director	15. Decedent's Ed	Jucetion	16e. D	ecedent's Usuel C	Occupetion		16b. Kind of Bu	siness/Industry		
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Se Other	17. Fether's Neme (First, Middle, Last)				18. Mother's Nem					
aryland 21215-00 should be filed within 72 hound be filed within 72 hound Mental Hygiene. marked other than "natural unatic event, the two call. To Be Completed	Philip (nmn)	Kueberth			Gertru	de (r	mn)	Yeakle		
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imore, M. Pages 1 end 2 nent of Health e nett if Nem 27 is	Anna Marie Kuebert	h - Wife			re Lane, Ede		MD 210			
Ore of H or oth	20a. Method of Disposition 1 to Burlel 2 ☐ Cremetlon 3 ☐	Removel from State	20b. Plece of D cemetery,	isposition (Name cremetory or othe	of or place)	Date	20c. Location -	City or Town, Stete		
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Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr ence.	21. Signature of Funeral Service/Light	M/100)			Address of Facility K. McComas	TTT Func	ral Hom	ρ D Δ		
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phys sthe	thet Initieted events resulting in deeth) Lest		Due to (or es e cor	sequence of):						
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Diversity of the dint	4 Homicide	m, Stete)								
Di Hospital or 24 hours afti Funeral Dir itely filled in	29a. Certifier 12 Certifying Ph	ysician: To the best of	of my knowledge, o	eeth occurred et t	the time, dete and piece,	end due to the	ceuse(s) end ma	nner as steted.		
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10+1	30. Name end eddress of person who	completed cause of d	eeth (Item 23a) (Ty	rpe, Print)						
,		4. D 768	O YORK	ROAD.	TOWSON, M	ARYLAN	D 212	04		
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District Control of Table Control States States States States There is interest.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth March **Physician** 1998 3:10PM BERNICE G. KITNER /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Fallston General Hospital Harford Fallston If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7/12/1923 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours 1□M 2XF Yrs. Director 190-12-1576 74 York, Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Expiring must be mortised at Director 1 ☐ Yes 2 No MD Harford Jarrettsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2757 Sharon Road 21084 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. "natural", or items 11 Maritel Status 72 hours after 1 ☐ Never Married 200 Married 1 Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. d 2 should be filed within I th end Mental Hygiene. 7 is marked other than "n Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be George Kingsbury Mary Geite 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 sh Department of Heelth end Important: If item 27 is m any injury or other traum Nancy L. Kitner/Daughter 2757 Sharon Road, Jarrettsville, MD 21084 20b. Piace of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removel from Stete Bel Air Memorial Gdns.3/18 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air, MD 22. Name end Address of Fecility Harkins Funeral Home, Is the disease, or complete tions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Harkins Funeral Home, Inc., Delta, PA Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final PROBABLY RELATED disease or condition resulting in deeth) Examiner Examiner attending physician and for use as the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest ECURRENT ATRIAL FIBRILLATION
Due to (or es e consequenca of): Physiclan/Medical EXACERBATION OF CHRUNIC BRONCHILAL edrs ASTHMA Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yae 2 No 3 Probably 4 Unknown OBESITY þ 24b. Were eutopsy findings evellable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturel 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Investigation 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) n by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner steted. 29a. Certifier Medicai completely (Check only one) 29b. Signature end title of certifing 29c. License number 29d. Dete signed (Month, Dey, Year) D18779 MARCH 15, 1998 . C. Jun. M. D 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ALBERT S. C. SUN, M.D.
31. Dete filed (Month, Dey, Year) 32/Registrar's Sign 1800 HARFORD ROAD, FALLSTON, MD 21047 32 Registrar's Signeture

DHMH 16 Ray 6/95

State

Registrar

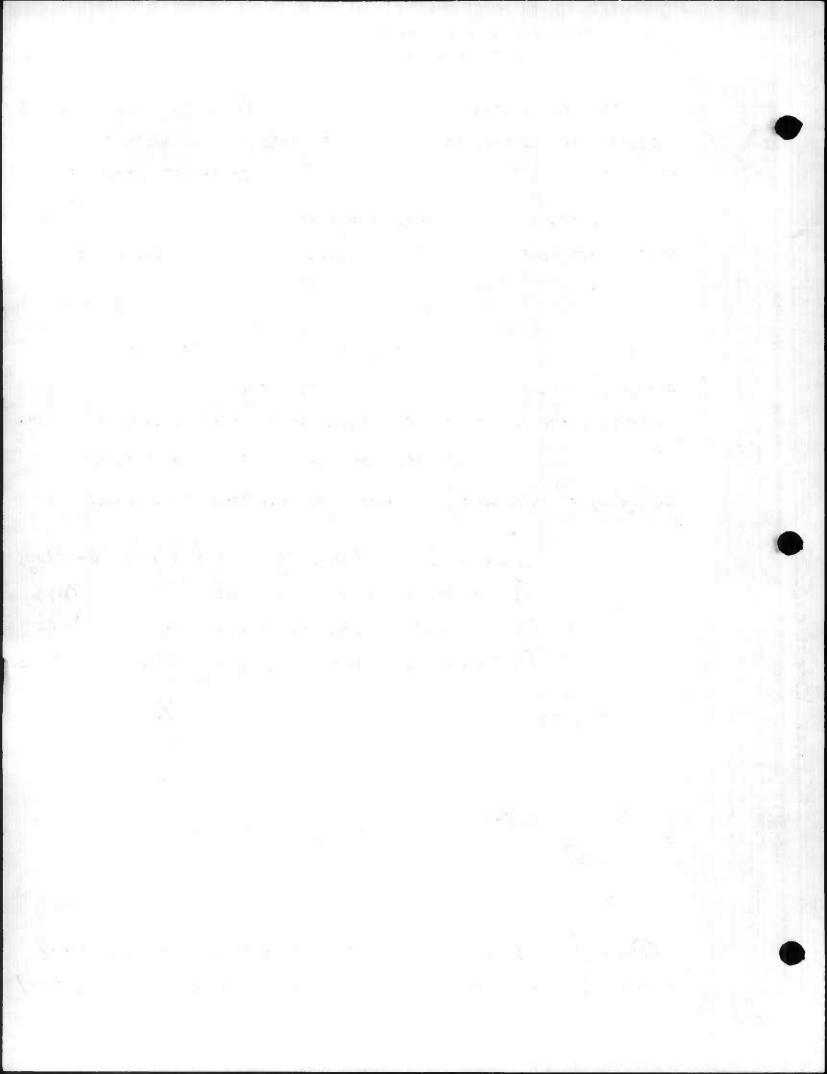
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Division



State of Maryland / Department of Health and Mental Hygiene 🛭 🤉

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of the Physician Raymond 6:45 A.M. Lewis Kaser March 16, 1998 /Medical 4e. Fecility Neme (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Day, Ye 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 1 MM 2□ F 74 Yrs 18, 1923 293-18-3951 Ohio Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Marvland Harford Director Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 58 Royal Terrace 21001 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Mayes 2 □ No If Yes, Give Yeer or Detes: WW II 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Medical Supply Clerk Civil Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles F. Kaser Della Chaney 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elisabeth Kaser (Spouse) 58 Royal Terrace, Aberdeen, Maryland 21001 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 12 Guriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Harfrod Memorial Gardens 3/19/98 Aberdeen, Maryland 21. Signeture of Funeral Servica Licansee 22. Name end Address of Fecility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 47 Unknown 1 Tyes 2 No 3 ☐ Probably by 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpetient 3□ DOA 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyaiclen: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) m.f. of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be nottled at

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Department of Health end Mentel Fingortant: If Itam 27 is marked or

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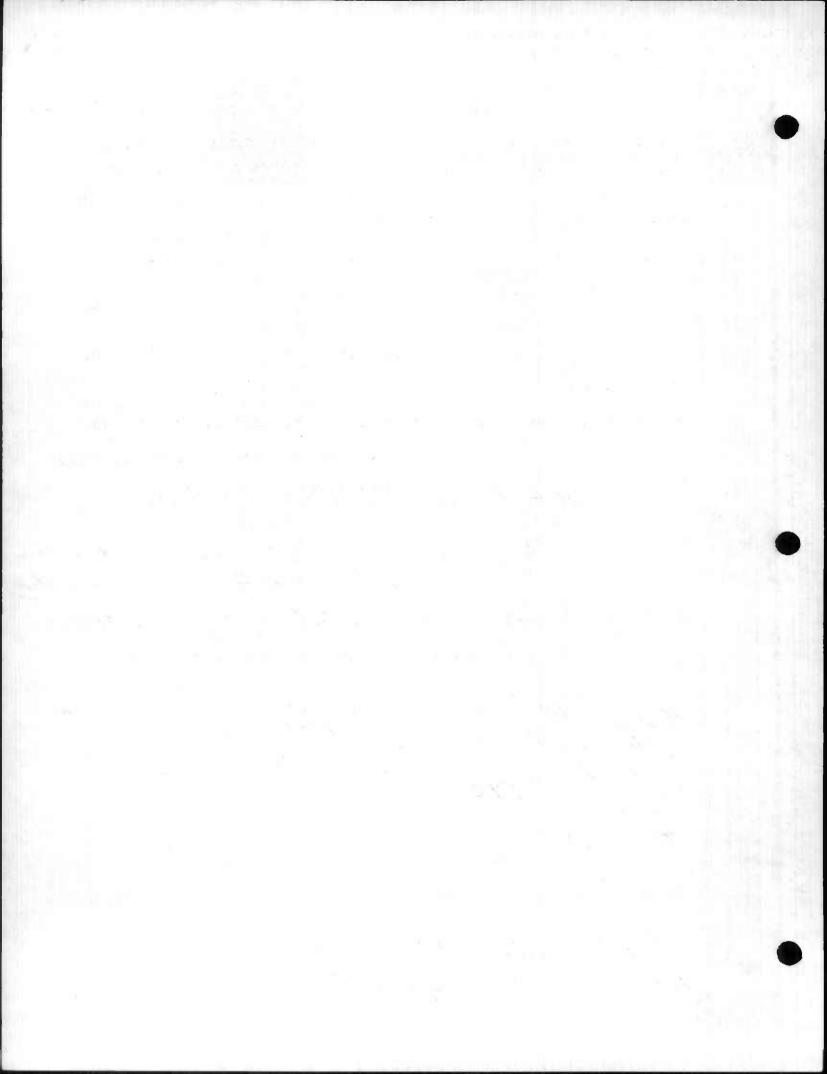
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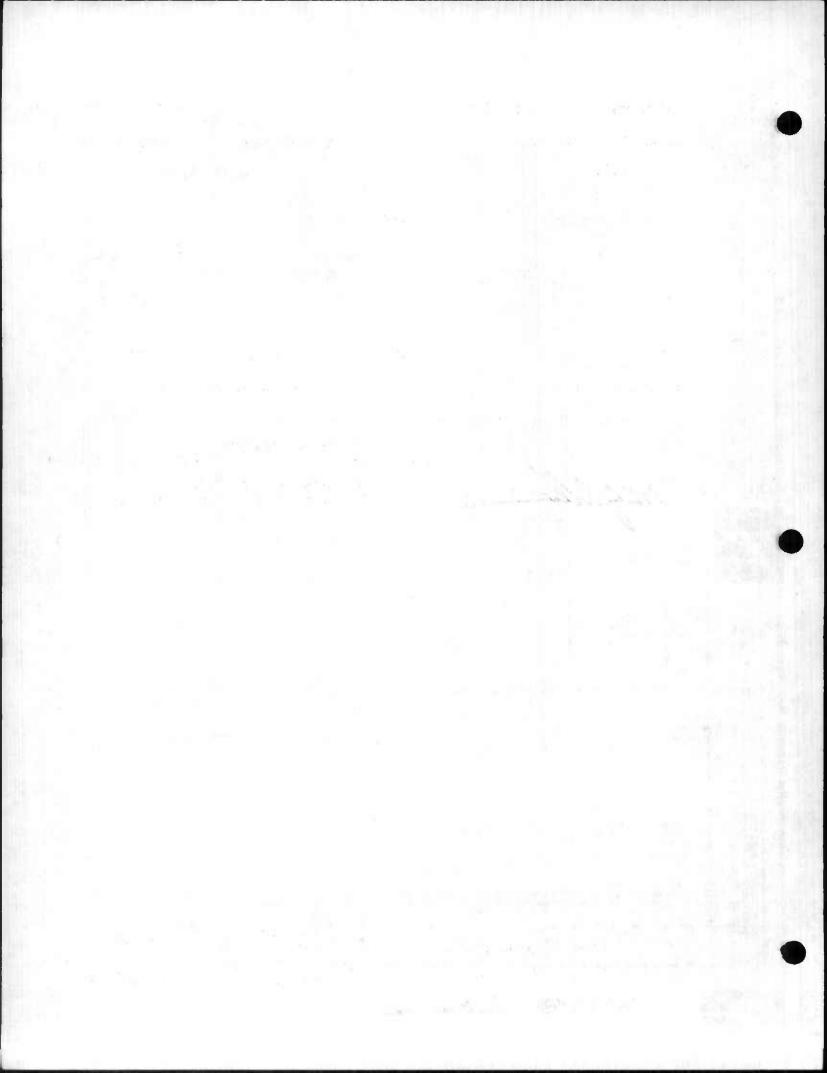
filed within 72 hours efter



State of Maryland / Department of Health and Mental Hygiene |

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** March 12, 1998 3:20 a.m. Kathleen Irwin Kaeppler /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Livingston Health Care Fort Washington Prince George | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | April | 14, 1899 | North Carolina 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 20 F 228-32-0374 99 Director Yrs. Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene.
ant: If Itam 27 ie marked other than "natural", or items 23s or 28s-f show ury or other treumstic event, the Medical Evant has the notified at 10a State 10h County 10c. City, Town or Location 10d. inside City Limits 1 XYes 2 □ No Director Maryland Charles Indian Head 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2 Elder Place Funeral 20640 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Jordan Latham Marion Rebecca Schmoele 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Itam 27 le any Injury or other tree Kathleen E. Gifford Daughter Same as #10 20b. Plece of Disposition (Name of cemetery, crematory or other placeMarch 16, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurlal 2 □ Cremation 3 □ Removel from State Portsmith, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Oak Grove Cemetery 21. Signature of Funerel Service Licen Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. disease, or complications that caused the death. Do not enter the mode of dylng, such as cardlec or respiretory arrest, failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel - Metastatie disease or condition resulting in death) Examiner Due to (or as a consequence of) The law requires that the death certificate be axecuted ettending physician and for usa as the buriel-tran Sequentially list conditions, if any, leading to immediate, cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1□ Yes 30 No Forhyth mia 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? rdio myosa completion of cause of death? certificate has 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this 27. Manaer of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 ☑Netural 2 ☐ Accident 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 Yes 6 Could not be determined 3 Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46285 MI 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 10905 Wasting Washin ton 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - AMEN Wed # 17, + 18 9 & Se, 3/10/98

1. Decedent's Name (First, Middle, Lest) Certificate of Death 2. Dete of Deeth Charles Month 3 Physician Kennedy /Medical 4e. Fecility Neme (If not institution, give street end rumber) 4b, City, Town, or Location of Deeth 4c. County of Death Examiner ST. Thomas More N+R(91, 4922 La Salle Ran HyatTSVille PRINCE GEORGE'S If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 6. Sex 1 M 2 □ F 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funerai** Yeer) Months 238-20-7148 Director WASHWION, X Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Exansiner must be notified at PRINCE Georges Director Yes 2□No 28a-f 10e. Street end Number 10g. Citizen of Whet Country? ò 4922 LASAIR Rd. U.S. A itams 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indien, Black. White, etc. should be filed within 72 hours after and Mental Hygiene. marked other than "natural", or its Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorcad Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN unknown UNKNOWN Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If flem 27 is marked other any injury or other traumatic event once. 18. Mother's Name (First, Middle, Melden Sumeme) Be WILLIAM Kennedy Bell UNKNOWN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1373 Adams STREET, N.E. WASHWITH DC 20018 James Dean Nephew 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State Dete 1 Buriai 2 ☐ Cremetion 3 ☐ Removei from State Glenwood Cembery Washington 3/26/98 4 Donation 5 Other (Specify)

21. Signeture of Funer Service Licensee Dunn + Sons Fun Leal Home

Seas EADs String N.E. Washington, DC

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. 20019 **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be assecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in deeth) Lest Box 68760. leratic Physician/Medical Pert il. Other algnificant conditione contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, by berehro Va Calan diseas 24b. Were eutopsy findings aveilable prior to completion of cause of death? Be Completed 24e. Wes en autopsy performed? this certificate 1 Tyes 2 □ No Division of Vital al or Attending Physician: The safter death.

In Director: After this certificate of in by the funeral director, pa 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide vithin 24 hours aft

To the Funeral DI

complately filled in 29a. Certifier 11 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 18198 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)
1328 SOUTHERN AVENUE #301, 3E WASHINTON 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State MAR 2 0 1998 Registrar

DHMH 16 Rev 6/95

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Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Plea	ase Type or P	rint in Bla Maryland								_	ible.		
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10e. Street and Number 18000 Catt	ail Road			10f. Zip	Coda	20	837		_		What Cou	st Africa	
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23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Finel disease or condition resulting in deeth)		utiple		Inje			cardiac	or raspiratory	arrest,	7	1	Approximata Interval Between Onsat and Death	
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Physician /Medical Examiner

After this certificate has

ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit

Completed by Physician/Medical Examiner Be Medical Certification: To

The law requires that the deeth certificate be axecuted Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funaral director,

31. Data filed (Month, Day, Yaar) State MAR 18 199 Registrar

25. Was casa rafarred to medical axaminar?
1 □XYas 2 □ No

29b. Signatura and titla of certifian

5 Pending

invastigation

6 Could not be detarmined

27. Mannar of Death

1 Naturai

2 Accident

3 ☐ Suicida

29a. Certifiar (Check only one)

4 Homicide

29c. Licensa number OCME

28b. Tima of Injury

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

0155

28c. Injury at Work?

1 Yas 2 ₹No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, end due to the cause(s) and mannar es stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated. 29d Data signed (Month, Day, Year) MARCH 14, 1998

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

Auto

24a. Was an autopsy pertormad?

1 Yas 2 No

28d. Describe how Injury occurred possering en

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

L - 2B

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24b. Wara autopsy findings available prior to completion of cause of death?

1 TYas 2 No

30. Name and eddress of person who complated causa of daeth (Item 23a) (Type, Print)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Deta of Injury (Month, Dey Year)

3-14-98

111 Penn Street, Baltimore, Maryland 21201

26. Placa of Death (Check only ona)

32 Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ion	Attending Ph or death. ector: After th by the funeral	ation	1 Natural 5 ☐ Panding 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 □	rk? Yes 2∐No		,,		
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	(4)		30. Neme and eddress of person who co	omplated cause of deeth (ite	m 23e) (Type, P	rint) TAKOMA	PARK,			-/ \	.0
	Sta	te	31. Dete filed (Month, Day, Year)	37. Registrar's Şigr	neture						

DHMH 16 Rev 6/95

Whitehall is good

MAR F F FIRM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Merum Leo L March -e 12,55 1998 8:05pm 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1**X**0 M 2□ F 578-22-3561 Yrs. April 10,1925 New York Usual Rasidance of Dacedan 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Washington, D.C. 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 5701 32nd St. N.W. U . S . A . 14. Race - Amarican Indian, Black, Whita, atc. 20015 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2☐ Married 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Tak-A-Toy Corp. Part Owner 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Fannie Leiter William Lewis 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Sarah Lewis / Wife 5701 32nd St.N.W. Washington, D.C. 20015 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Judean Mem. Gdns. 3/16/98 Olney, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21 Signature of Funaral Sarvis 22. Nama and Addrass of Facility Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast shock, or haart fallura. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown -vien 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy periormed? 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical Examiner -transit pue

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

the

Baltimore, Maryland 21215-0020

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is merked other than any Injury or other treumstic event.

Physician/Medicai þ Be Completed ٩

that the deeth certificate be executed P.O. Box 68760, physician the been signed t should be det Records, page 2 certificate of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Division

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida edicai 29a. Cartifiar 1 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

> 29c. Licansa number D 38435

29d. Data signed (Month, Day, Year)

S. te 3c7 Silver Span, Mil

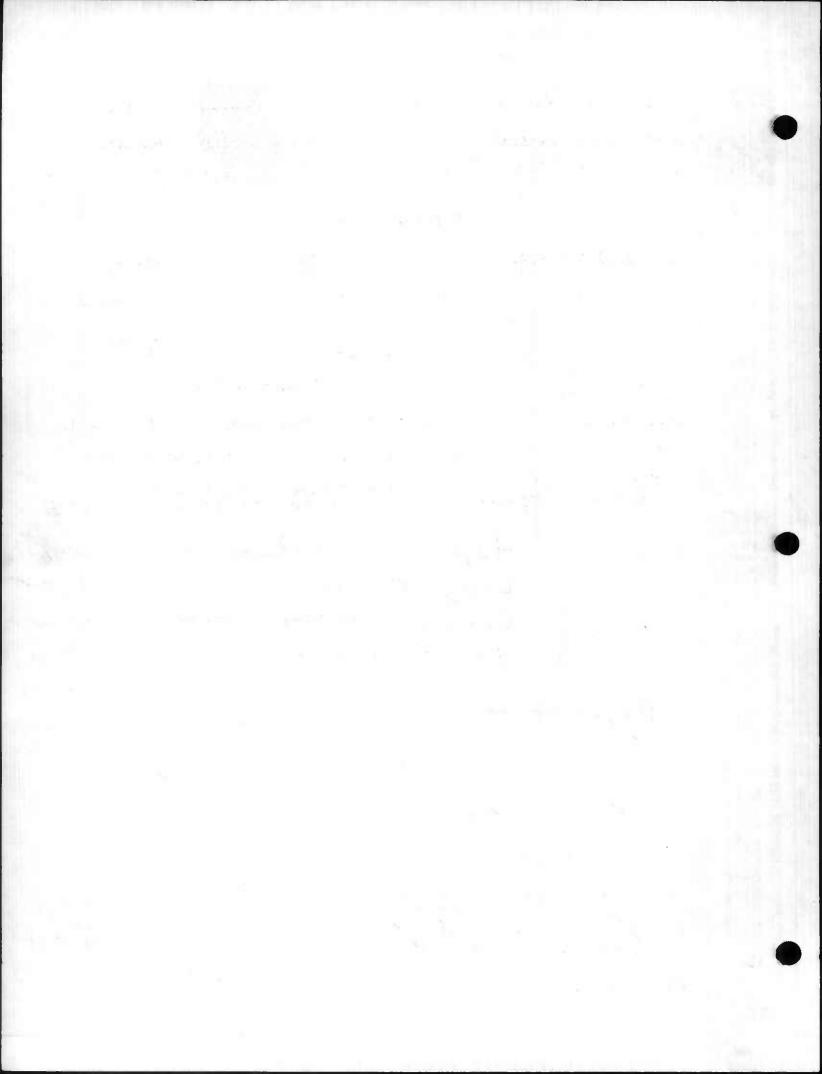
30. Nama and addrass of parson who complated ceusa of death (Itam 23a) (Type, Print) Ken: 3 ver 10313 31. Data filed (Month, Day, Year) MAR 18 1

29b. Signature and title of certifier

Genga

32. Registrar's Signatura

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Suh-er Liang 16, 1998 March 12:37 PM /Medicai 4e. Facility Name (If not institution, give street and number) 4b City Town or Location of Deeth 4c. County of Death Examiner 15771 Buena Vista Drive Montgomery Derwood 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 31, 1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Deys Director 64 Yrs. 366-64-1722 Taiwan Usual Residence of Decedent the Meryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15771 Buena Vista Drive United States 20855 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 72 hours sitar 1 ☐ Never Married 2 Narried 1 ☐ Yes 2 ☑ No Specify: þ Specify: Taiwanese 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 7 Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Laboratory Technician Biomedical Research permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If Nem 27 Is marked other tany Injury or other traumatic auch. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Ying-kuan Wen Shiu-ing-mei Liu 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Yung-san Liang/Husband 15771 Buena Vista Drive, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place March 21, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 300 West Montgomery Avenue Rockville, Maryland 20850-2805 shock, or hear failure. List only one cause on each line. Approximate Onset end Death **Physician** /Medical Immediate Cause (Final Hanging Acute disease or condition resulting in death) Examiner Dua to (or as a consequenca of): physician end s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or Injury that initiated avents resulting in death) Last Dua to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) 88 attending for usa as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed b þ 24b. Were autopsy findings evallable prior to completion of cause of daeth? Completed 24a. Was an eutopsy performed? Deed pega 2 1 ☐ Yas 2 ☑ No 1 ☐ Yes 2 ☐ No certificata or Attending Physician: Be 25. Was casa raferred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🖾 Residence 8 Other (Specify) 1⊠Yes 2□ No Certification: To this 27. Manner of Death 28b. Tima of 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 No Hanging 2 Accident March 16, 1998 Director: A 6 Could not be determined 3 X Sulcida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida #10 within 24 hours a
To the Funeral C Hospital 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: De the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) manner stated. Medical 29a. Cartifier (Check only 29b. Signature and title of 5 0 ense number 29d. Date signed (Month, Day, Year) D07099 March 16, 1998 30. Name and address of person who complete auth of death (them 23s) (Type, Print)

10215 Fernwood Road, Bethesda, Maryland 20817

State Registrar

Francis C. Mayle, Jr.,

31. Date fited (Menth, Day, MAR 2

M.D.

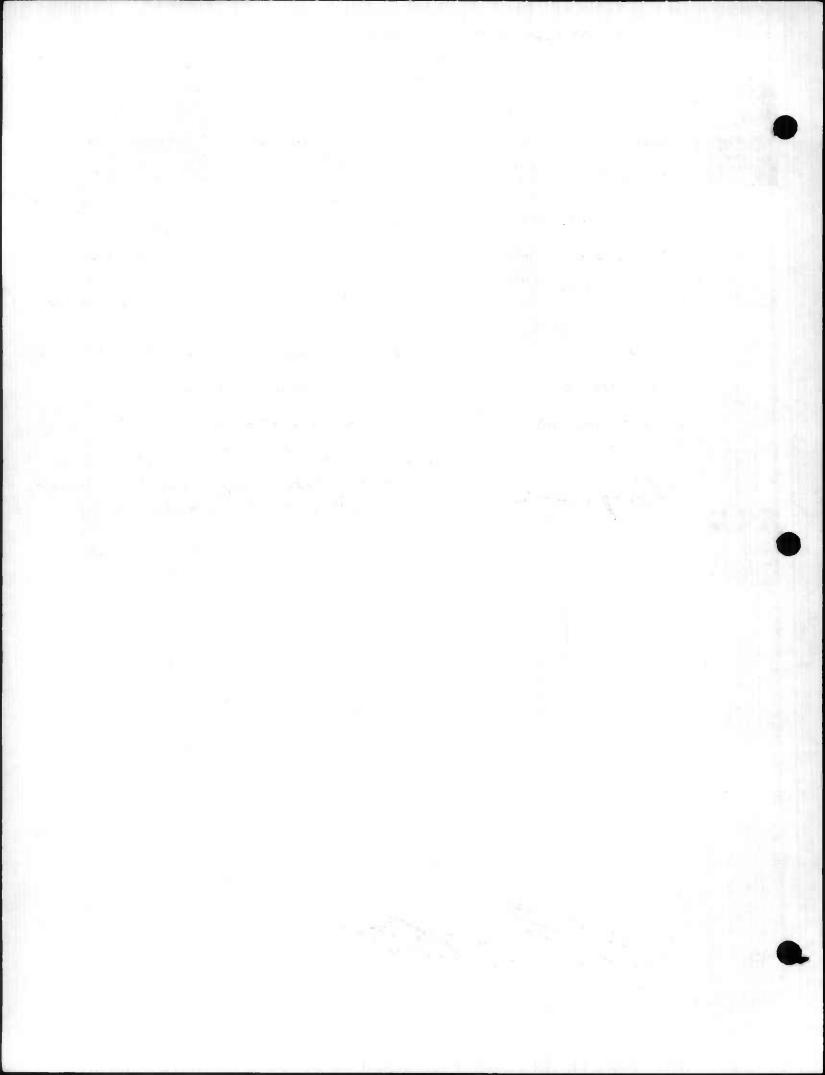
Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

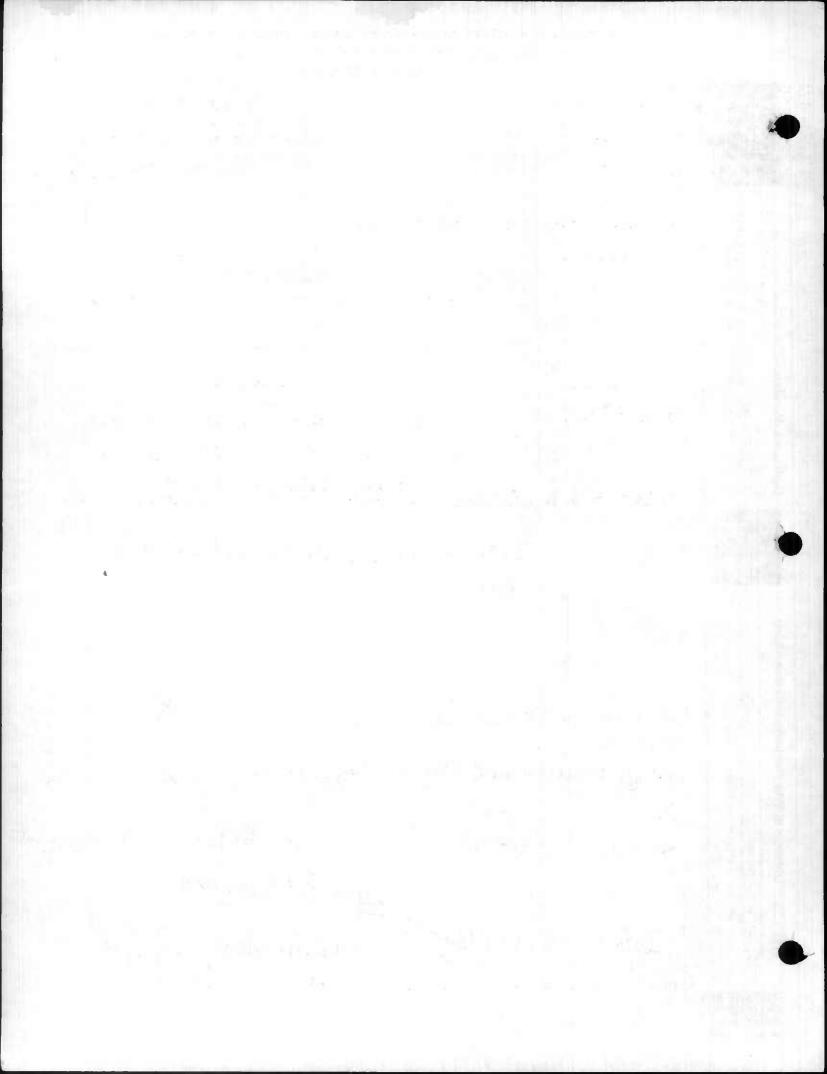


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			5. Social Security Number 579-10-7400	6. Sex 1	7. Age (In y	rs. last birthda Yrs.	Months Deys		8. Dete of Birth OCT. 23,1918 Washin				r Foreign
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020	E Sel	by Fu	1 ☐ Never Married 2 ☑ Mail 3 ☐ Widowed 4 ☐ Divorced	ried types Gi	2 No	WII	1 ☐ Yes 2 ☐ No		to Alcan, etc.)		ck, White,		
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no	ling P	Certification:	27. Manner of Deeth 1 □Neturei 5 □ Pendii		of Injury	28b. Time Injury	W			low injury occur		ad out	OMONT
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	To the Hospital or Attending Phys Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	edical C	29e. Certifier (Check only one) Certifying Certifying Certifying	ng Phyalcian: To the Examiner: On the ba	best of my k	nowledge, dee	th problem of the	ime, dete end ptece opinion, death occu	, and due to the irred et the time,	ceuse(s) end me dete end pleca,	enner as st	eted. the ceuse(s))
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1998 MAR. 11, **Physician** 5:50PM DAVID /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BETHESDA MONTGOMERY SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 6. Sax 1 2 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
JUL. 16,1909 5. Sociel Security Number Birthplace (Stata or Foraign Country) **Funeral** Months 88 Yrs 142-10-4334 Director Usuai Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes TNo Director MONTGOMERY CHEVY CHASE 10e. Street end Number 10f. Zlp Code 10g, Citizen of Whet Country? 20815 USA 8100 CONNECTICUT AVE., #1515 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: by Specify. 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) **JEWELER** RETAIL / OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Surnama) Be BESSIE KRUPENIN MICHAEL LEBSON 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DEBRA L. JACOBS / DAUGHTER 4445 ROCKCREST DR., FAIRFAX, VA 22032 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL CEMETERY 3/13/98 PARAMUS, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funerei Service Licensee Pure The disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only ona causa on each lina. Onset and Deeth **Physician** /Medical Immediata Cause (Final RENAL FAILURE 1 WK. disease or condition rasulting in death) **Examiner** Due to (or as a consaquence of): Examiner MYOGLOBINUNA 1 WK. Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Causa (Disease or Injury that initioted events resulting in daath) Last Due to (or as a consequence of): RIGHT LEG ISCHEMIA 1 WK. Physician/Medical Due to (or as a consequenca of): SEVERE DEHYDRATION 1 WK. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown POLYCYTHEMIA VERA þ 24b. Were autopsy findings evaltable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Be 25. Was cese rafarred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residance 6 Other (Specify) 1 Yes 25€No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be datarmined 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To tha best of my knowledge, death occurred at tha time, data and place, and due to the ceuse(s) and mannar as stated.

2 Madical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) MOUAS, ND daath (Itam 23a) (Type, Print)

Simonds, DefM. Medical Education, Suburban Hopital, Between

State Registrar 31. Date filed (Month, Day, Year)

DHMH 16 Ray 6/95

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Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 1 Department of Health and Mental Hygiens Important: if tem 27 is marked other than "n any Injury or other traumatic even."

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within 24 hours e To the Funeral D completely filled

Box 68760.

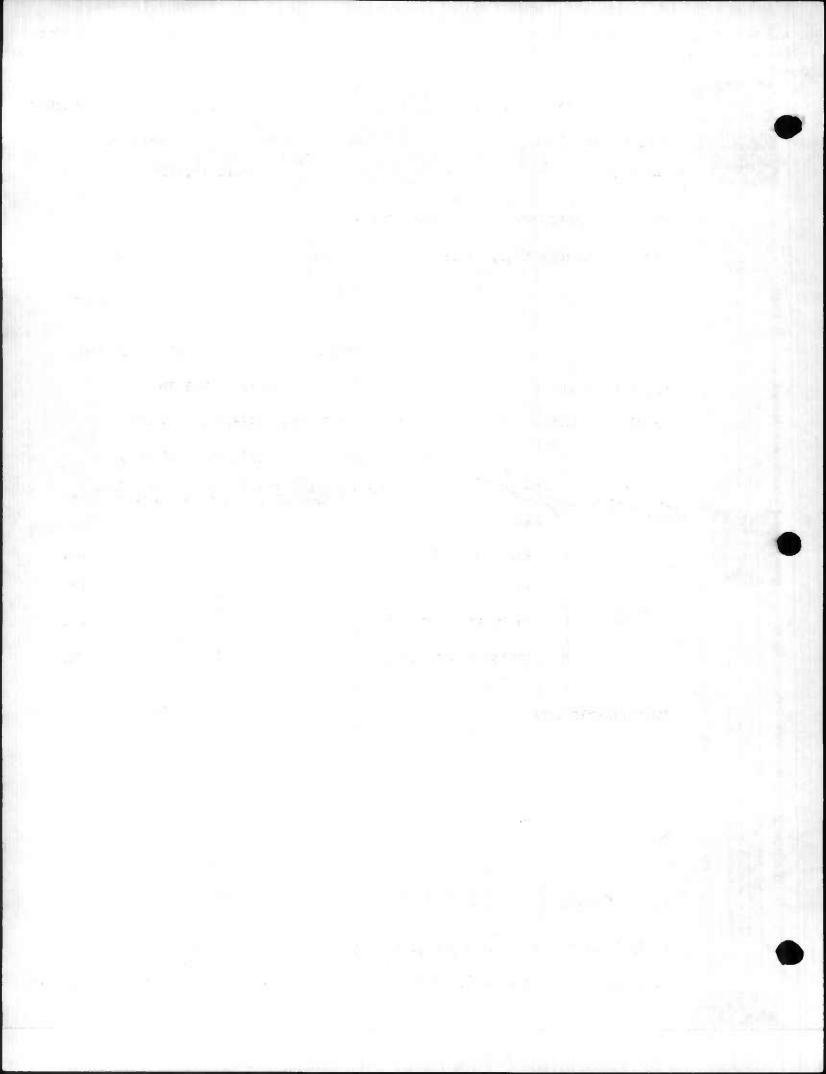
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Division of Vital Records.

David

To the Hospital or Attending Physician: within 24 hours efter death.

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Amend # 19b, 3/23/98, BMW, Manta, Co. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev **Physician** 2:40 PM Marvin Jerald Lawrence March 14, 1998 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6231 Spring Hill Drive, Apt. 103 Greenbelt Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1₽M 2□F Months Yrs June 9, 263-72-2460 53 Florida Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10e Stete 10b. County 10d foside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar mast be notified as 1 Yes 2 No Director Prince Georges Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 72 hours efter death with 6231 Spring Hill Drive, Apt. 103 20770 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ▼Yes 2 □ No
If Yes, Give
Year or Detes: 1962-68 14. Race - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 7 Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) 12 Foreman Pepco 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 should be fi Lillie Mae Brinson Lloyd Lawrence 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20770-14201 Grand Pre Rd Apt A-2; Silver Spring, MD 20906 6231 Spring Hill Drive, Apt. 103, Greenbelt, MD permit. Peges 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 19e. Informent's Name/Reletionship (Type, Print) (wife) Peggy L. Lawrence 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State MD Veteran's Cemetery 3/18/98 Cheltenham, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Francis J. Collins France, Inc. 500 University Blvd. West Francis J. Collins Funeral 21. Signatu e d Funeral Service Licensee Home, Inc. tronc 20901 Silver Spring, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physiclan** /Medical Immediate Cause (Final . Can dece disease or condition resulting in death) anna Examiner Due to (or es e consequence of): Ob Struction. Examiner Com on ant Er requires that the death certificate be executed iclan and burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to or as e consequence of) physician s the buria Box 68760. Physician/Medicai Due to (or es e consequence of): 80 the etter 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Ö detact signed by d 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? been : The law hes 1 Yes 2 No Smo /2; 1 □ Ves 2 □ No this certificate NC Physician: 25. Wes case referred to medical examiner? funeral director, Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 -No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending Neturel 1 ☐ Yes 2 ☐ No Investigation 2 Accident

Division of Vital Attending death. To the Hospital of within 24 hours at To the Funeral D completely filled in

after death Director: / the filled in by

3 Sulcide 4 Homicide

29a. Certifier

6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rurel Route Number, City or Town, State)

29b. Signeture end title of certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (flem 23e) (Type, Print)

Kathleen McShane, M.D. MER

m 8 20774

State

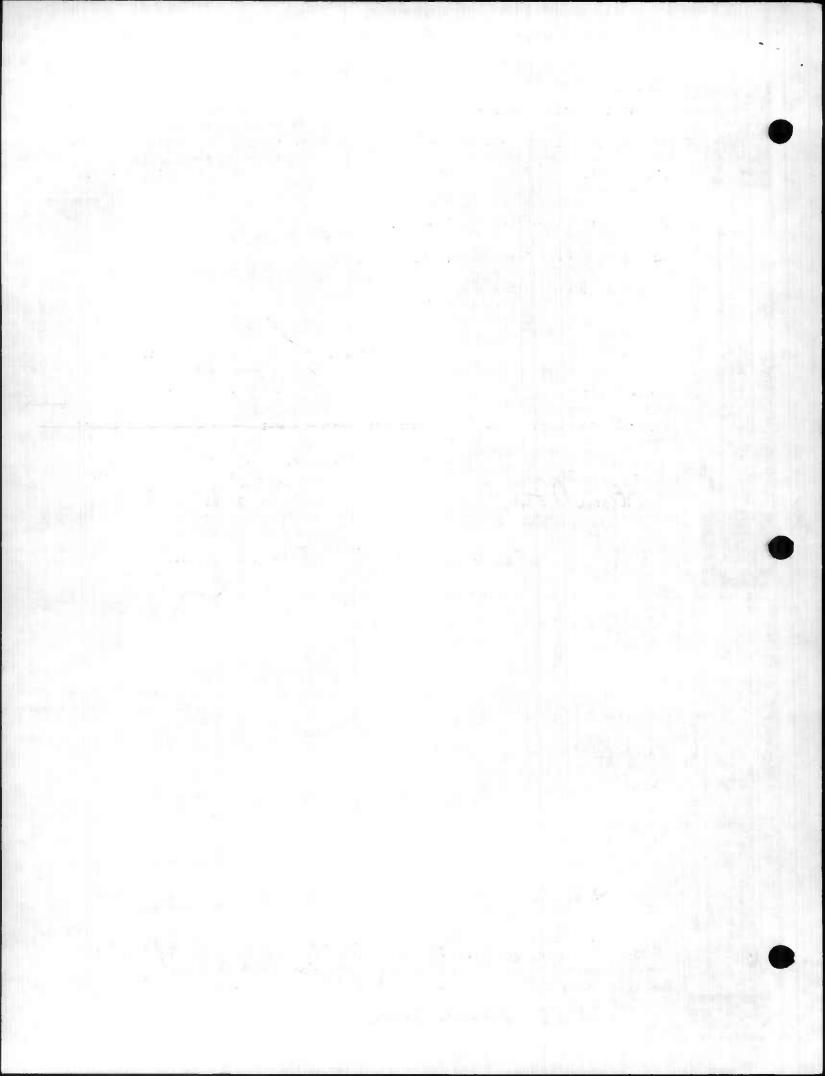
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Kaiser 31. Date Red (Month, Day, Year)
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Registrer's Signeture

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth LONG 19:30pm LOIS JANE March 17,1995 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth If Under 1 Year | If Under 24 Hrs. | 8. ate of Birth (Month, Day, June 13 Cambridge Dorchester General Hospital Dorchester 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign 1 M 2 1 Mary land 220-26-3002 Usuei Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20 No Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2011 Dailsville Rd. 21613 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas — 25 No If Yes, Give/ Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American indian, Bieck, White, etc. 1 Never Married 25 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Coliaga (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Leslie Oneita Robbins Claude Truax 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 2011 Dailsville Rd., Cambridge MD 21613 Lewis L. Long, Jr. - husband 20b. Pieca of Disposition (Neme of cametery, cremetory or other piece) 20c. Location - City or Town, Stete TEBuriai 2 Cremation 3 Removel from Stete Dorchester Memorial Park 3-21-98 Cambridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility
Thomas Funeral Home PA Kennetto R Thom 700 Locust St. Cambridge, MD 21613 23e. Pert1. Entar tha disease, or complications that caused the daeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximata intarvai Between Onset and Deeth immediate Cause (Fine) disease or condition resulting in death) Stroporosis 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of daeth? 1 Yes 2 No

Physician /Medical Examiner

Box 68760

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Funeral

Director

? Is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

should be filed within 72 hours nd Mental Hygiene. marked other than "natural",

2 should be fi

permit. Peges 1 end 2 should be Department of Health end Mental Important: If Item 27 is marked or any injury or other traumatic ev

burial-transit Physician/Medical the should be det by Completed pege 2 al or Attending Physician: The setter deeth.

I Director: After this certificate of in by the funeral director, pe Be Certification: To To the Hospital or within 24 hours eff To the Funeral Di completely filled in

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certificate

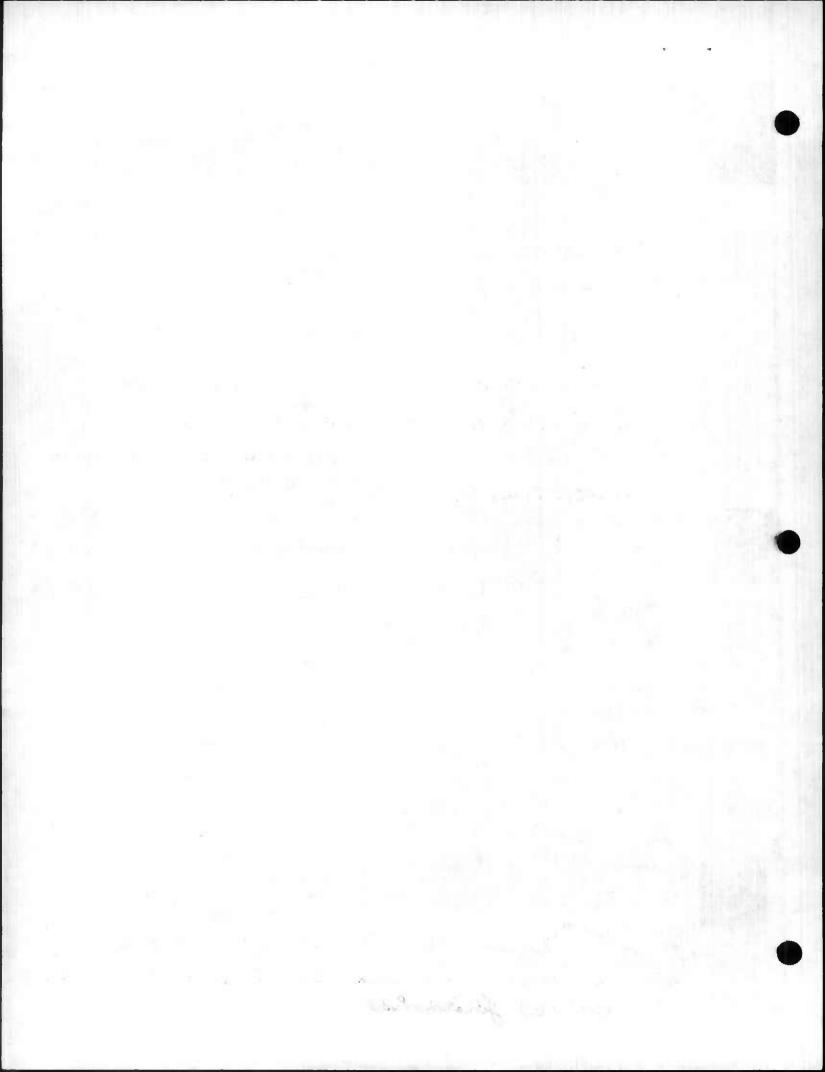
Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Pert II. Other significent conditions contributing to daeth but not resulting in the underlying cause given in Pert I. 25. Was case rafarrad to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residance 6 Other (Specify) 1 Yes 2 YNG Palepatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, data end plece, end due to the cause(s) and menner steted. 29b. Signetura end title of content? 29c. License number 29d. Date signed (Month, Dey, Year) D 0050 987

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)
Almed Nawa 3 105 Aurora Succet Cambridge MD 21613

MD

32. Registrar's Signetura

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time th **Physician** Month ARTHUR C LEVERETTE MARCH 17, 10:32 P.M. 1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number if Under 24 Hrs. Birthpiace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 X M 2 □ F Months Days Yrs. Director 84 DEC. 12, 1913 GEORGÍA 242-01-8318 Usuai Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7631 GREENLEAF ROAD 20785 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritei Status Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. TYes 2□No 1941-f Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 1945 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTOR 8 CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 2 OTIS LEVERETTE, SR. LIZZIE MARTIN 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JERALDINE M. LEVERETTE, WIFE 7631 GREENLEAF ROAD, LANDOVER, MARYLAND 20785 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e, Method of Disposition Date 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 3/23/98 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Liceg. 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 tran 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS day diseese or condition resulting in death) Due to (or es a consequence of): Examiner day PNEUMONIA. Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown fibrillation , Parkinsonism. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? PEG tube feeding. @ Recurrent Pneumonia. 25. Wes case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ► ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) by lyan and are 50653 3/19/98 M.D. 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) GYAN CHAND SURANA SURRATTS 7501 ROAD. CLINTON. M.D.

State Registra

31. Date filed (Month, Day, Yeer)

32. Registrar's Signature

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"natural", or items 23s or 28s-f ehor

permit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itel any july or other traumatic event, trained to any injury or other traumatic event, trained any injury or other traumatic event, trained any injury or other traumatic event, trained any once.

Physician /Medical

Examiner

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Aftar

filled in by Funeral Direc

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To

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

of Vital Physicien:

Division or Attending

Baltimore, Maryland 21215-0020

The state of the s

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) Month Day **Physician** GWENDOLYN EUGENIA MARCH 14, 1998 LINDSEY 1:15 P.M. /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner TEMPLE HILLS
If Undar 24 Hrs. 8. Date PRINCE GEORGE'S 3128 BRINKLEY ROAD, #204 If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foraign
Country) **Funeral** 1□ M 2XF Daya Months Hours Min Yrs. 46 MAY 5, 1951 Director 577-66-9717 WASHINGTON, DC Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND PRINCE GEORGE'S Directo TEMPLE HILLS 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? must be n Items 23a 3128 BRINKLEY ROAD, #204 20748 Funeral UNITED STATES 12. Was Dacedent Evar In U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Stetus Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after of peginnent of feetilh and Mental Hygisons.
Important: If liem 27 is marked other than "natural", or less any injury or other traumatic event, the Medical Examines and ance. 1 ☐ Yas 2 📉 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 X Married 1 ☐ Yas 2 ☒ No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Buainass/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) SUBSTANCE ABUSE COUNSELOR COUNSELLING 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Fathar's Nama (First, Middle, Last) ISAAC ROBINSON RUTH PINKARD 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3128 BRINKLEY ROAD, #204, TEMPLE HILLS, MD DARRYL LINDSEY, HUSBAND 20748 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from State 4 □ Donation 5 □ Other (Specify) FORT LINCOLN CEMETERY 3/19/98 BRENTWOOD, MARYLAND 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Ocentura FORT LINCOLN FUNERAL HOME MUSON 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 22 Part /Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Acoured Immunodeparacy Syndrome /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Examiner physician and the bunal-transit the death certificate be executed Sequantially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequança of) as t USB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t P 24b. Ware autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of daath? certificete has t lirector, pege 2 s 1□ Yes No 1 □ Yas 2 □ No Attending Physician: 25. Waa cesa rafarrad to madical axaminar? Be 26. Placa of Daath (Check only ona) To Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No deeth. 2 Accidant investigation after deet Director: 6 Could not be datarmined 3 Suicida Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 6 4 Homleida ò filled in • Funeral Hospital 29a. Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated edical Sempletely (Check only within 2 5 29b. Signatura and titla of certifie 29c. License number 29d. Dala signad (Month, Day, Year) Tol complated causa of death (Itam 23a) (Type, Print) Nama and addrass of parse ane excausile au 31. Data filed (Manth, Day, Year) MAR 2 1998 32. Registrar's Signatura

DHMH 16 Rev 6/95

Registrar

WAS BURED JULIAN COLE

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 4e. Facility Neme (Knot institution, giva street and number) MARCH 4c. County of Death 1998 :53pm LONG /Medical 4b. City, Town, or Location of Deeth Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY COUNTY TAKOMA PARK 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funerai** Days Months Yrs. Director 218-66-1407 58 1939 WASHINGTON, DC Usuel Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Maxical Examinar must be notified at 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 12301 PROSPECT LANDING UNITED STATES Funeral 20721 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) Race - American Indian, Bleck, White, etc. 11. Merital Status 1 and 2 should be filed within 72 hours effer Health end Mental Hygiens. em 27 ia marked other than "natural", or Ita 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: WHITE by n Yes, Give Yeer or Detes: Specify: 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry COMMERCIAL Elementery/Secondery (0-12) College (1-4or 5+) ASSEMBLER CONTRACT WORK 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be HENRY F. LONG 2 ELSIE C. KIDWELL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 Department of Health et Important: If Item 27 ia any Injury or other trau once. SONNY LONG, BROTHER 12301 PROSPECT LANDING, MITCHELLVILLE, MD 20721 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta Dete 1 Buriei 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 3/18/98 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or hear feiture. List only one cause on each line. Approximete Interval Betwe **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical **Examiner** Due to (or es a consequence of): Examiner physician and the buriel-transit ABdomINAL certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Box 68760. Physician/Medical the Due to (or as a consequence of) 80 esn ō P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, b 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificiety filled in by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 12 Yes 2 No 27. Menner of Deeth Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 TYes 2 No 6 Could not be determined 3 Suicida 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to tha ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner steted. 29a. Certifier Medical completely (Check only one) phin 2 29d. Data signed (Month, Day, Yaer) 29b. Signatura and titla of certifie 29c. Licansa number

7600 CAKKOLL AVE.

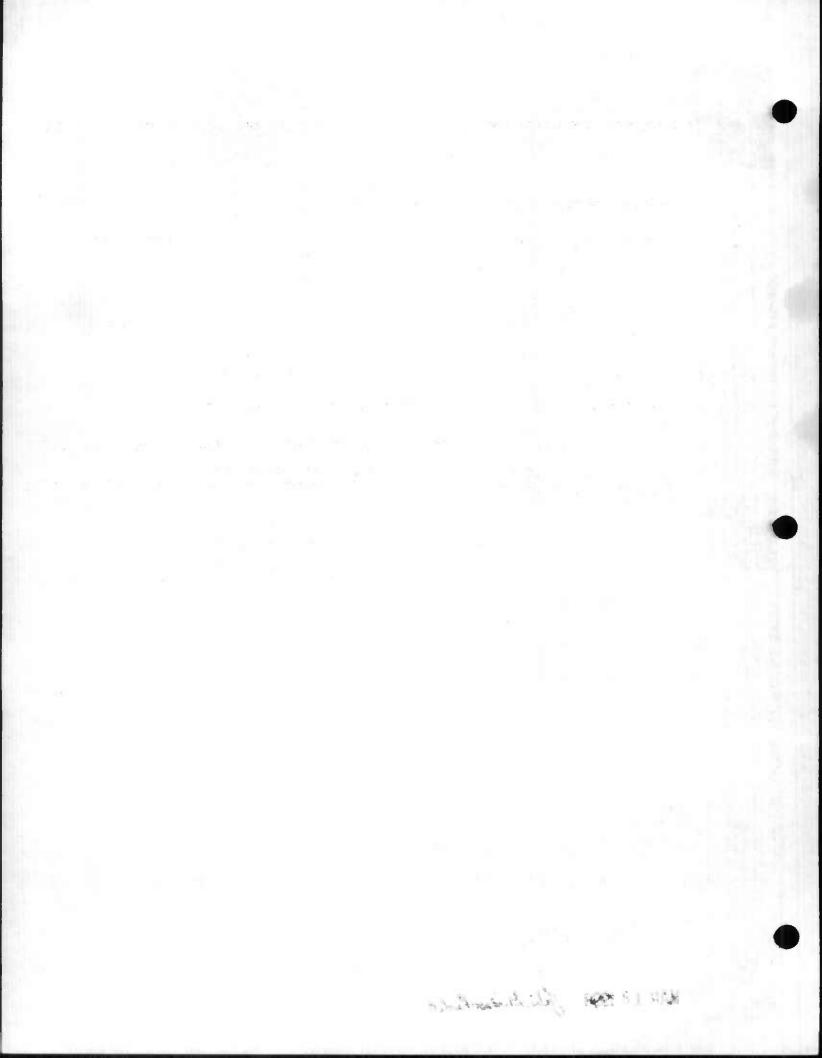
State Registrar 31. Dete filed (Month, Day, Year)

MAR 18 1998

Jahan

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 10:55 PM 1) ANIGH 1998 MARCH 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year NOV. 5, 1 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) 1⊠M 2□F 478-10-8442 Yrs Iowa Usuel Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Takoma Park Maryland Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20912 United States 8308 Barron Street, #6 12. Wes Decadent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 4 X-ray Technologist Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Walter Unavailable Η. Madden 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, Cify or Town, State, Zip Code) (wife) Same as 10 Agnes A. Madden 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Chesapeake Crematory 3-20-98 Beltsville, Maryland 21. Signeture of Funerel Service Licensee Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910

23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approx 22. Neme end Address of Fecility Approximete Intervel Between Onset end Deeth Immediate Cause (Final Metostatic Small Cell Corcino mo diseese or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequença of) Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physiclan /Medical Examiner

physician end the burial-transit

signed by I

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

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P.O. Box 68760

Records.

Division of Vital

Physician

/Medicai

Examiner

Directo

Funeral

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Examiner

Physician/Medical

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Certification:

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Funeral

Director

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e filed within 7. el Hygiene.

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permit. Pages 1 and 2 should be 1 Depertment of Health end Mentel I Important: If Item 27 is marked of any Injury or other traumatic eve

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Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Lest

Lenkopenia

24a. Wes en eutopsy performed?

24b. Were autopsy findings evaileble prior to completion of cause of deeth?

1 Yes 2 No

28d. Describe how Injury occurred

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Lukia Davidson

27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 1 X Naturel 5 Pending 2 Accident Investigation

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

3 ☐ Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or Investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted. 29c. License number

29b. Signature and title of certifier

6 Could not be determined

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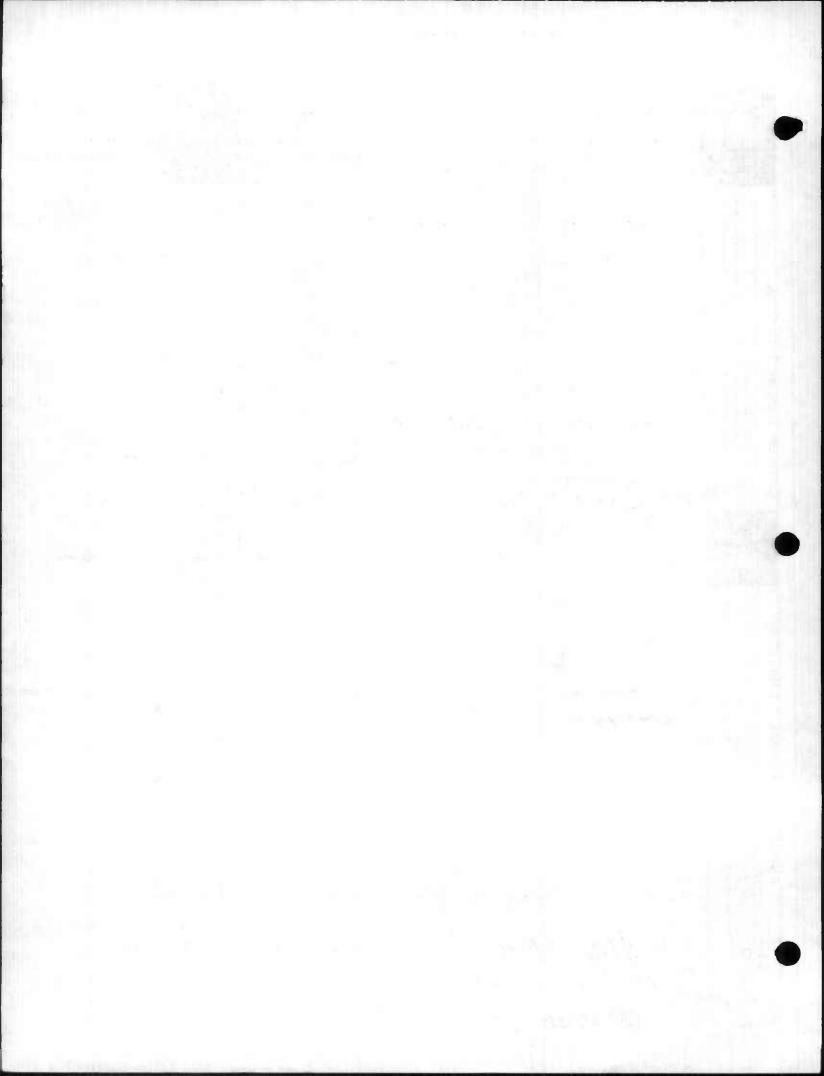
28c. Injury et Work?

29d. Dete signed (Month, Dey, Year)

30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

9013 Flower Ave. Silver Spring, Md. 20,901-4043 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture

State Registrar



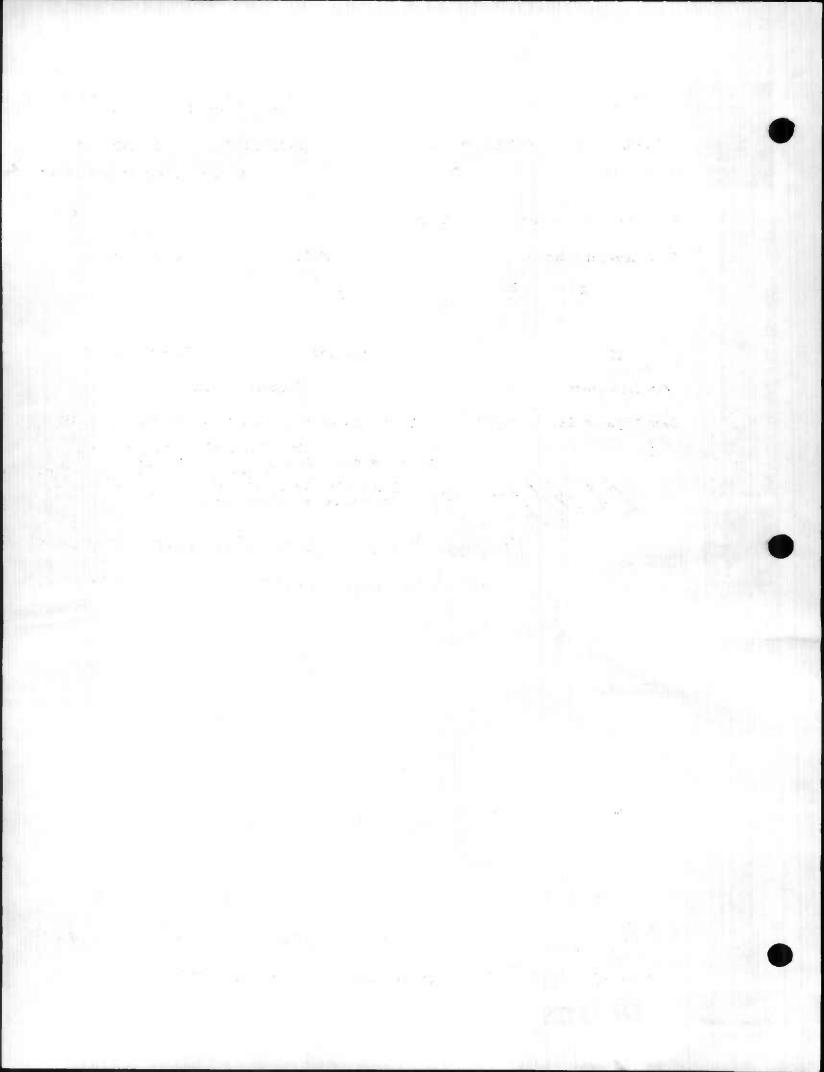
Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland /	Certificate of		Reg. No.	10109			
Physician /Medical		B. MAG	MANELLI	SR. MA	RCH 18,1	Year 2330 m			
Examiner Funeral Director	4e Facility Name (If not institution, give SHADY GROVE A 5. Sociel Security Number 6. Se	DVENTIST HOSE	PITAL	ROCKVILLE If Under 24 Hrs. 8. Date Hours Min. Nov.	of Birth	TGOMERY 9. Birthplace (State or Foreign Country) Massachusetts			
show	Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits			
the M	Maryland Montgom	nery Rock	ville 10f. Zip Code		10g. Citizen of V	1 ☑ Yes 2 ☐ No What Country?			
23a or	5721 Crawford Driv			851		States			
urs after alf, or its boy Fur	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes: WWII	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☑ No	dispanic Orlgin? (Specify Yes en, Mexican, Puerto Rican, et Specify:	c.) Blac	e-American Indian, ck, White, etc. v: White			
ed within 72 hours af ygjene. • reten "netural", or it,	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation 16	Ga. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working d)		uainess/Industry			
THE PERSON	12 17. Fether's Neme (First, Middle, Last)		Courie	18. Mother's Name (First, M		Government			
d 2 should by the and Menta 7 is marked traumatic extraumatic extr		ype, Print) 1	9b. Mailing Address (Street	Carmella Ga	11a Gangi Rural Route Number, City or Town, State, Zip Code)				
of Heal Itam 2 other	John Magnanelli, 20a. Method of Disposition 1 \(\mathbb{\text{\ti}\text{\texi{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi{\texi\text{\text{\texi}\text{\tinte\tai\texi{\text{\texitile\text{\text{\texi}\texit{\tet	Removal from State	of Disposition (Name of stery, crematory or other plan		20c. Location - Silver	City or Town, Stele			
permit. Pages 1 ar Department of Hea Important: If Itam, any Injury or other pnce.	4 Donation 5 Other (Specify 21. Signature of Fundal Solvice Licent		Rockville,		Marylar A. Pumphre st Montgom	nd y Funeral Home			
Physician /Medical Examiner Examiner Examiner	23a. Part 1. Enter the disease, or omposhock, or heart failure. List only of the disease or condition resulting in death) Sequentially list conditions,	BRIPHBELL BAO STATE				Interval Between Onset and Death I WEEK 4 Years			
ficate be physicians the burner of the burne	Cause (Disease or Injury that initiated events resulting in deeth) Lest	cDue to (or as e consequence of):							
d by the detached	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given	ven in Part I. 23t	o. Did tobacco use co	ontribute to the cause of death?			
requir hould				24a	. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
sicien: The law scentificate has biginector, page 2 s					1□ Yes 25tNo	1 ☐ Yes 2 ☐ No			
Physician: this certific ral director,	25. Was case referred to medical examiner?	Hospital: 1 Manpatient 2 ER/	Outpatient 3 DOA Ott	26. Place of Death (Check		ner (Specify)			
After fune		28a. Date of Injury (Month, Day Year)	b. Time of Injury M 1	rk? IYes 2 □ No	scribe how injury occur				
To the Hospital or Attending P within 24 hours after death to the Funeral Director: After it completely filled in by the funeral Medical Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		City	or Town, State)	ber or Rural Route Number,			
thin 24 hos thin 24 hos the Fun mpletely		Iner: On the basis of examination and manner stated.		opinion, death occurred at the	time, date and placa,				
10+1	29b. Signature and title of certifier	MO	Sac. Floati	WHEATON	MARCH	1 19, 1998			
	30. Name and address of person who can RAYMONO BAS	completed cause of death (Item 23)	a) (Type, Print) ARA DRIVE	WHEATON	MARYLAND	20906			
State	31. Date filed (Month, Day, Year)	Registrar's Signature		-					

Registrar

MAR 20 1998

July Saidson Rondelle



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amend #19b, 3/20/98, BMW, Montg. Co Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Lillian Month **Physician** Karp Marin 14, 1998 March 8:05 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Randolph Hills Nursing Home Montgomery Wheaton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Yeer) 3 Selrthplace (State or Foreign Yuly 26,1913 New York **Funeral** 1□M 2(XF Months Deys Hours Yrs Director Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 20906 10g. Citizen of Whet Country? 0 with 13303 Holdridge Road 238 U.S.A. pemit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "naturel", or items 23a any injury or other traumatic event. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bieck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ģ Specify: White f Yes, Give reer or Detes: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Meyer Karp Sophie Berkowitz 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Holdridge Rd., Silver Spring, Md. 20906 Leon H. Marin-Husband 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Buriei 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Judean Memorial Gds. B/15/98 Olney, Maryland of Funeral Şervice licen 22. Name and Address of Facility
Ives-Pearson Funeral Homes 2847 Wilson Blvd., Arlington, Va. 22201 23e. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximete Intervai Between Onset and Deeth **Physician** /Medical Immediate Cause (Finei disease or condition resulting In death) yea. Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. attending physician for use as the buris Physician/Medicai Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? certificate has 2 PNo 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 inpatient 2 ER/Outpetient 3 DOA 28e. Date of injury (Month, Dey Year) 27. Menner of Deeth 28h. Time of 28d. Describe how injury occurred 28c. Injury et Work?

Division of Vital Records, P.O.

the á

or Attending Physician: efter death. Director: After this certifica To the Hospital or within 24 hours aft To the Funeral Di completely filled in

> State Registrar

Medical

29b. Signeture end title of cartifier

5 Pending

investigation

6 Couid not be determined

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. License number D41931

1 🕒 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Dey, Year) March 14, 1998

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme end eddress of person, who completed cause of deeth (Item 23e) (Type, Print)

Shoretield Road Wheaton MD 20902 MD 2309 Shumache

31. Dete filed (Month, Day, Year) 18 1998 MAR

1 Naturel

2 Accident

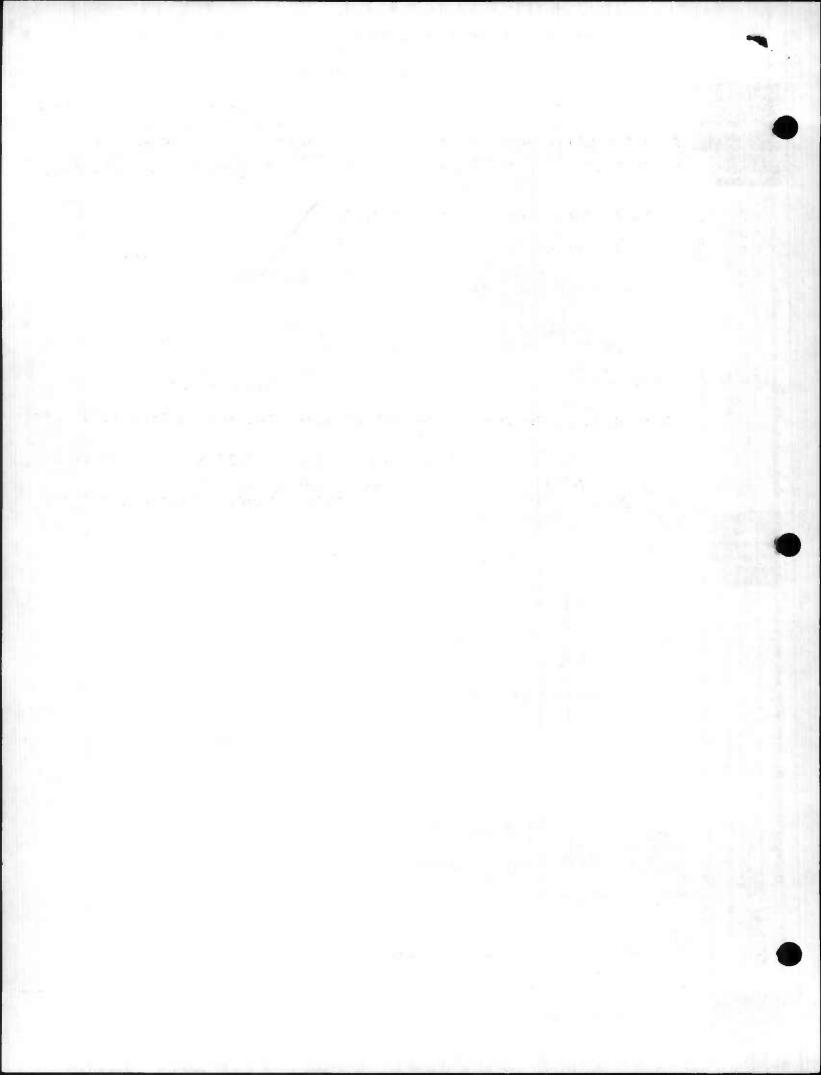
3 ☐ Sulcide

29a. Certifier

4 - Homicide

(Check only one)

32 Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Amend #5, 3/23/98.BMW.Montg. Co. Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Lest) 3. Time of Deeth 2. Date of Death .^{Da}ĭ998 MARCH 18, **Physician** MARILYN S. MORRIS 8:45 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner MANOR CARE HEALTH SERVICES, INC.-POTOMAC POTOMAC MONIGOMERY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdev) 6. Sex 8. Date of Birth (Month, Dev. Year) **Funeral** Deys Hours 1 □ M 2 🔀 F Months Director 07/05/1917 NEW YORK Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10e Stete 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "naturef", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 TYes 2 XNo Directo MONIGOMERY MARYLAND POTOMAC 10a. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 10714 POTOMAC TENNIS LANE 20854 UNITED STATES OF AMERICA Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Biack, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Peges 1 and 2 should be filled within 72 hours effer tent of Heelth and Mental Hygiene.
nt: If item 27 is marked other than "naturef", or item 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced WHITE Year or Detes Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER NAVAL ARCHITECTURE 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Be PAULINE BLIDNER HENRY SILVERDRATH To 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) SARA BYRD GOLDBERG NIECE 15443 FAGLE TAVERN LANE, CENTREVILLE, VIRGINIA 20120 other 1 Baltimore. 20e. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 XBurlei 2 ☐ Cremetion 3 ☐ Removel from State 6 4 □ Donetion 5 □ Other (Specify) 03/22/1998 OLNEY, MARYLAND JUDEAN MEMORIAL CARDENS 21. Signeture of Funeral Service Inconsee 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Blund 23e. Part1. Enter the creese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or the arrive. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel **PNEUMONTA** DAYS disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner bunel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest and Due to (or es a consequence of) that the death certificate be exec Box 68760 physician Physician/Medical the th Due to (or es e consequence of) 560 attending 980 5 23b. Did tobacco use contribute to the cause of death? the Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by t 1 No 3 Probably 4 Unknown COPD Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed peen performed' PRIOR STROKE hes page 2 1 TYAS 2 No 1 T Ves 2 1 No certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 8 Other (Specify) 1º 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Neturel 5 Pending investigation death. 1 Tyes 2 Accident after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. edicai 29a. Certifier completely To the To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier MARCH 19, 1998

State Registra

31. Dete filed (Month, Day, Yeer) MAR 20 1998

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)



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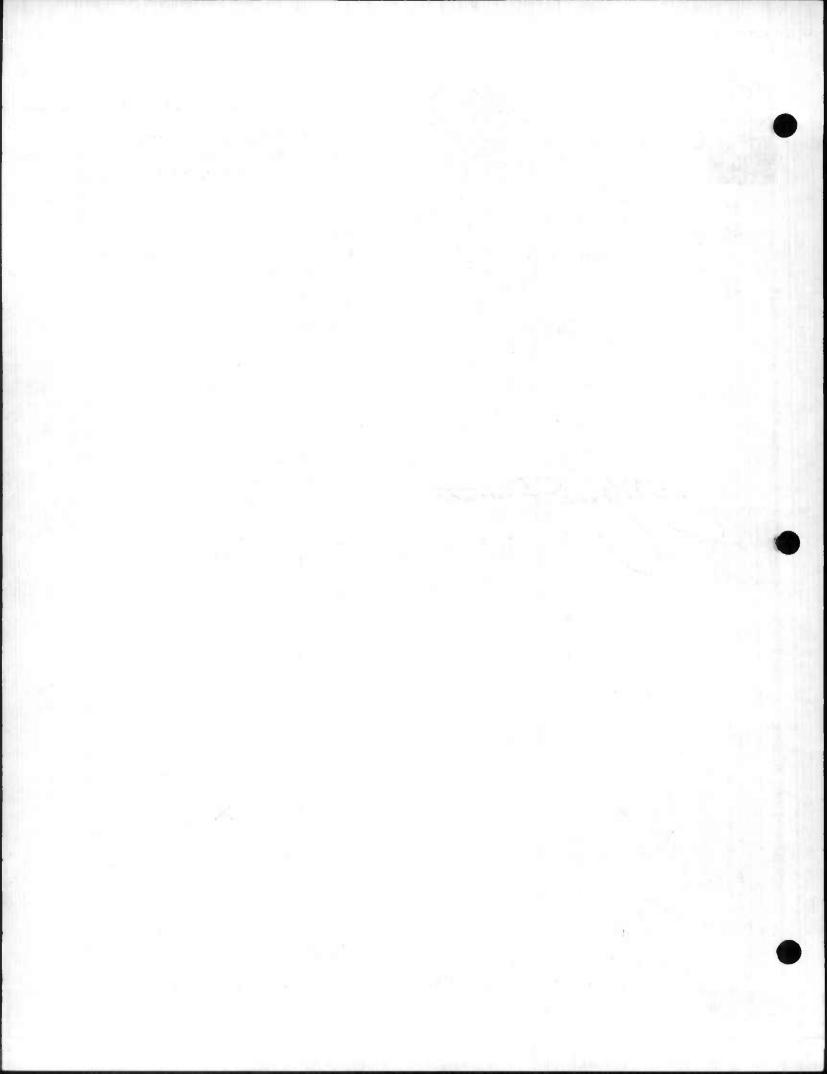
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 9

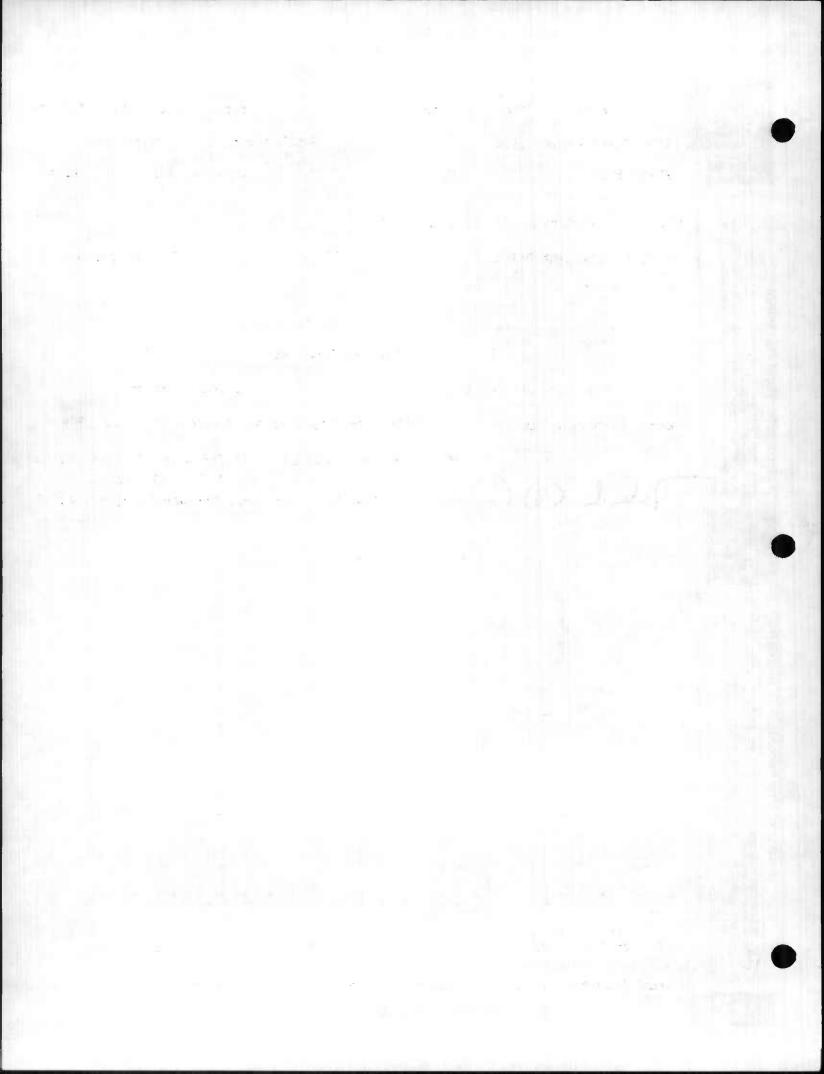
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	or 2	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
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Baltimore	Department Department Important: any injury once.		21. Signature of Fungral Sepribe I	icensee	. /	22	Name and Addre	ess of Fecility Funeral	Tanada -	T		
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	ding Ph h. After th funeral		27. Menner of Deeth Naturei 5 ☐ Pending	28e. Dete (Mon	of injury 2 oth, Day Year)	8b. Time of Injury	28c. Inju	ry et rk?	28d. Describe h	ow injury occur	теб	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Affer th completaly filled in by the funeral	edical	Other Day 24 Medical E	and toen	asis of exemination iner stated.	n end/or inve	stigetion, in my o	opinion, deeth occur	red at the time, o	ete and piaca,	end due to	tne ceuse(s)
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n	Kevin	Sean	Martin				Month March	Day 17. 1	Year 998	7:50 AM	
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5. Social Secu			e (In yrs. las		der 1 Year	If Under 24 Hrs	s. 8. Date of Bir			(State or Foreign	
170-62	-6496	M 2□F	28	Yrs. Month	ns Days	Hours Min	Nov. 7	1969	New J		
10a. State	10b. County		10c. City, 1	Town or Location			10d. Inside City Lin				
Marylan 10e. Street and	nd Montgom	ery	Gai	thersbur			10g. Citizen of What Country?			1 ☐ Yes 2 ☒ No	
				101.	Zip Code			Tog. Citizen of v	viiat Country i		
	Wheelwright		Drive 20879 2. Was Dacedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yas, specify Cuban, Mexican, Pu				Specify Vee or No		State		
	vs Married 2⊠ Married ed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑				Specify	k, White, etc.			
	15. Decedent's Ed	ducation		16a. Decedent's U	sual Occul	petion	- 4.5	16b. Kind of Bu			
	Specify only highast gra Secondary (0-12)	da completed) College (1-4or :	5+)	(Give kind of life. DO NO)	work done Luse retire	during most of wo d)	orking				
E.o.nontory/		4		Financ	ial A	nalyst		Но	tel		
17. Father's Na	me (First, Middle, Last)						ame (First, Middle	, Maiden Sumam	10)		
17, Fathers Na	Jay Ron	ald Mart:	in				Linda	Plan	k		
	's Neme/Relationship (19b. Meiling Addre	ess (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip Coo	de)	
Lorna	B. Martin/	Wife		19801 Whe	elwr:	ight Dri	ve, Gait	hersburg	, MD.	20877	
20a. Method o	Disposition		20b, Plac	e of Disposition (/	Vame of		Date	20c. Location -			
	2 XCremation 3 ☐ ion 5 ☐ Othar (Specifi			opolitan		-	3/17/98	Alexand	ria. Vi	Irginia	
21 Sonature	of Funeral Service Licen	isee O		2		on of English	DeVol Fu				
116		A Com	1.0. a.	1 4 10 5	. 5					00077	
23a Part1 Fr	ter tha disaase, or com	nlications that caused	the death	10 Eas	ode of dy	er Park ng. such as cardia	Dr., Gai	thersbur		208// proximate	
Immediate Ca disease or cor resulting in de Sequentially li it any, leading cause. Enter	dition	e	Due to (or a	fu m o	of):						
Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury											
resulting in de	rents	d	Due to (or as a consequence of): d.								
							ant But				
I Part II. Other a	gnificant conditions o		ut not resulti	ng in the undarlyin	g cause gi	ven in Part I.	23b. Did	tobacco usa co		s cause of death ly 4 ☐ Unknow	
								Van 204 Main		, TOTIKIO	
	Nohe	2					1 🗆	Yes 2 No	0_110000		
	Noha	2					24a. Was	Yes 2 No s an autopsy ormed?	24b. Were	autopsy findings ble prior to etion of causa th?	
-	Noha	2					24a. Was	an autopsy ormed?	24b. Were availat compli of dea	ole prior to etion of causa	
25. Wes case	No 4	2				26. Place of De	24a. Was	an autopsy ormed?	24b. Were availat compli of dea	ole prior to etion of causa th?	
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DHMH 16 Rev 6/95



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Dey 1998 Month **Physician** Richard Α. Martin March 16, 1:04 PM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth Months Days Hours Min. May 21, 5. Social Security Number Birthpisca (Steta or Foreign Country)
 Maine 7. Aga (In yrs. lest birthdey) **Funeral** 10 M 20 F Yrs. Director 006-14-0504 Usuel Residence of Decedant death with the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10348 Democracy Lane 20854 United States 12. Wes Decedant Evar in U,S. Armed Forcas? 1 1 Yes 2 □ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, etc. 11. Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "naturel", or then eny Injury or other traumatic event the 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Yaar or Dates: WW II Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Technology/Aerospace/ Elementery/Secondery (0-12) College (1-4or 5+) General Accounting Office Attorney 6 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Richard A. Martin Byars Avis 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mildred O. Martin Same as 10 (wife) 20b. Plece of Disposition (Neme of cematary, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Dete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 3-17-98 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) Chesapeake Crematory 22. Nama and Address of Fecility 21. Signature of Funerel Service Licensee Rapp Funeral Services, P. A. lee 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate interval Between Onset and Deeth Physician Immediate Cause (Final disaesa or condition resulting in deeth) /Medical Branca pheumonia
Due to (or es e consequence of): Examiner Examiner signed by the attending physician end if be detached for use as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disaase or injury that initieted evants rasulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Artery Disease 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy certificate hes 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: Attending 5 Pending investigation 1 Neturel death. 1 Yas 2 No 2 Accident To the Hospital or Attence within 24 hours efter death To the Funeral Director: 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, deta and piece, and due to the ceusa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred et the time, deta and piece, and due to the cause(s) end mennar stated. 29e. Certiflar Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 1033357

20815

5530 Wisconsin Ave Chery Chare

State Registrar 00

30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

Registrer's Signeture

Lite Burdson

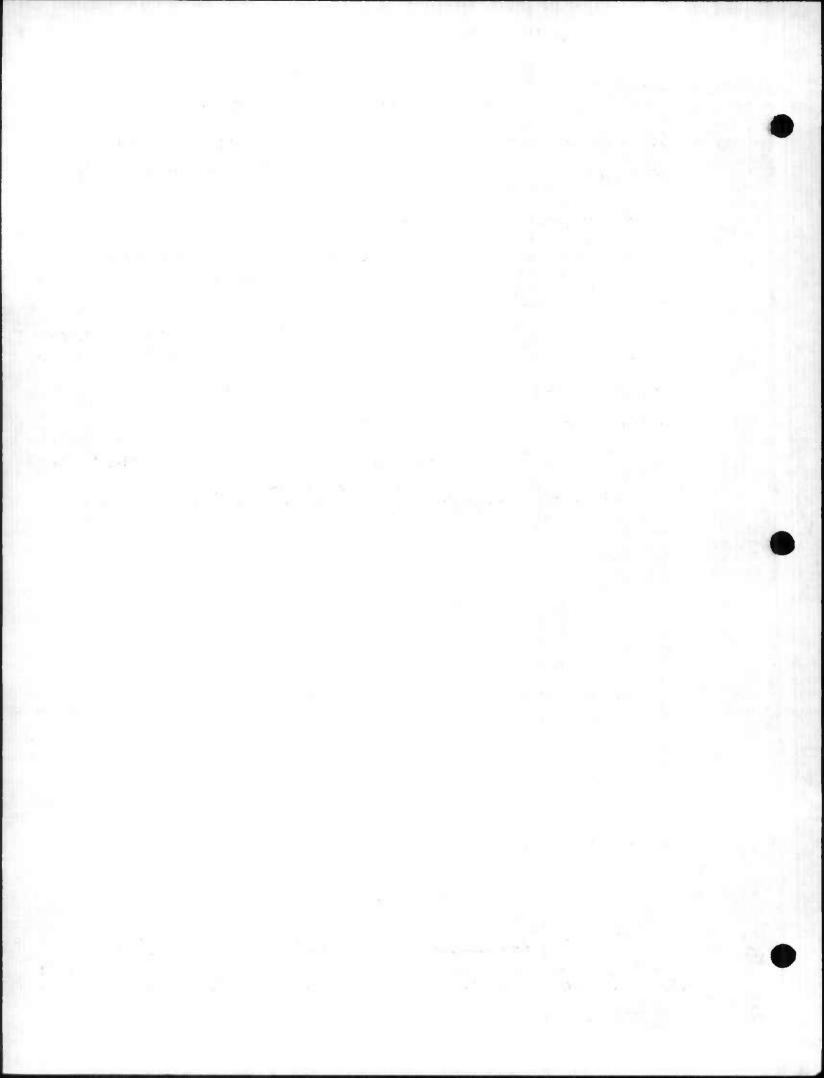
Jonatha

18 1998

31. Date filed (Month, Dey, Year)

MAR

DHMH 16 Rev 6/95



Please Typ

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State of Maryland / D	epartment of Health and M	lental Hygi	ene 9	8 1	0 1	1	5
	Certificate of Death	Re	g. No.			•	
's Name (First, Middle, Last)		2. Dete of Deeth Month	Day	Year	3. Ti	ime of	Dea
DEPTY MACE MACON							

Physician /Medical **Examiner**

1. Decedent's Name (First, Middle, Last)

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

Be Completed by Physician/Medical Examiner

Medical Certification: To

To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlet-transit

Division of Vital Records, P.O. Box 68760,

DEITI PACE							MAR		3	1998	3 6:0	02 P.M.
4e. Facility Name (If not institution, NATIONAL NAVAL	give street end numbe MEDICAL C	enter				WN, or Lo	ocation of Dea		c. County MONTG			
5. Social Security Number 220-16-7887 Usual Residence of Decedent	6. Sex 7. A 1 M 2 S F	Age (In yrs. lest b		Under 1 Yeer onths Days		24 Hrs. Min.	8. Date of B (Month, D March I	irth Dey, Year 19, 1	926	COL	place (S intry) ylan	tete or Foreign
10a. Stete 10b. County		10c. City, Tox	wn or Locatio	on							10d. fnsi	de City Limits
Maryland Montgo	omery	Roo	ckvill	.e								Yes 2⊠No
10e. Street and Number			1	Of. Zip Code				10a C	itizen of V	What Co.	intn/2	
14005 Flint Rock	. Dond			oi. zip oode	2085	2			ted :			
11. Marital Status	12. Wes Deceden	t Ever in II S	12 Wee	Decadent of			noity Vac or N					90
1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces	3? I No	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☒ No Specify: 1□ Yes 2☒ No Specify: White							, etc.	ari,	
15. Decedent's		168	a. Decedent's	s Usual Occu	petion	t of work	ina	16b.	Kind of Bu	usiness/li	ndustry	
(Specify only highest Elementery/Secondary (0-12)	College (1-4o	r 5+)	life. DO N	of work done NOT use retire	ed)	t OF WORK	ing					
	5+		Teache	r				E	duca	tion		
17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Neme	First, Middle	e, Meide	n Sumem	10)		
Charles B. Mad	ce				Ad	a Le	е					
19a. Informant's Name/Reletionsh			-				el Route Num					
Hugh C. Mason(h	usband)	14	4005 F	lint R	ock Ro	oad,	Rockv	ille	, Mai	ryla	nd 2	0853
20a. Method of Disposition		20b. Plece cemet	of Disposition	n (Neme of ny or other pla	coMarch	17	1998	20c. l	ocation -	City or T	own, Sta	ite
1 ☑ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		Park1	awn Me	emoria.	l Park			Roc	kvil	le,	Mary	land
21. Signature of Funeral Service L	icensee	M00109	Robe 755	me and Addr	ess of Facility Pumph onsin	rey Ave	Funera nue 2081	1 Ho	me/Bo	ethe Ch	sda- ase,	Chevy Inc.
23a. Part1. Enter L. diseese, or o shock, or heart feiture. List o	complications that cause	M00198 ed the deeth. Do	not enter th	hesda, e mode of dv	Mary	Land	2081	4-35 arrest.	01		Appro	xlmete
shock, or heaft feilure. List o	nly one cause on each	line.								i	interva	al Between and Death
Immediate Cause (Finel	SMAI	LL CELL	LUNG (CANCER						i		
disease or condition resulting in deeth)	a	Dun to force o								-		
		Due to (or as a	consequen	ce of):						1		
Conventially list conditions	b	Due to (or as a	CORRAGUAN	ne of):								
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due 10 (01 a3 a	Consequen	00 01).								
that initiated events	c	Due to (or as a	consequence	se of).						-		
resulting in death) Last		Due to (01 as a	CONSEQUENC	<i>y</i> 01).								
	d											
Part II. Other eignificant condition	e contribution to death	but not requiting	in the under	hina agusa a	ivon In Bod (22h D#	1 toheoo	0.1180.001	ntelburto :	to the or	use of death?
	o contributing to count	Dat Hot resulting	in the direct	ying oddso g	NOT HIT WILL	•			2□ No		obably	
							1	, , , ,	20110	00111	Judisty	4 GOIRIOWII
							24a. Wa	s an eut formed?	opsy	a	vailable i	opsy findings orior to n of cause
							1	Yes :	No		☐ Yes	2□ No
25. Wes case referred to medical					28 Place	of Deet	n (Check only	- 10				20110
examiner? 1 ☐ Yes 2 ☒ NĂ	Hospital: 1 Tinpa	tient 2 ER/O	lutestient 3	DOA O	hor:		me 5□Res		s □Oth	or /Snac	(64)	
27. Manner of Death	28a. Dete of In		Time of	28c. Inju			28d. Describe				··y/	
1 Natural 5 Pending 2 Accident investiga		ley Year)	Injury		ork?]Yes 2□	No						
3 Suicide 6 Could no determin	ed 28e. Place of I	njury - At home, f etc. (Specify)	arm, street,	factory, office			28f. Location City or To			er or Rui	ral Route	Number,
29a. Certifier (Check only one) Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner s	of examination e	e, death occ nd/or investi	curred at the t getion, in my	ime, date an opinion, dea	d placa, a	and due to the	e cause(, date ar	s) and ma	nner as and due	stated. to the ca	use(s)
29b. Signature and title of certifier	1			29c. Licen	se number			29d. D	ete signe	d (Month	, Dey, Ye	ear)
V Johnson	of Leve, n			Do	0528	24		M	rch	14 1	590	
1 proces	A LCDC. N	16 WN		-20	0000	- 1		1,10	un	11,1	116	

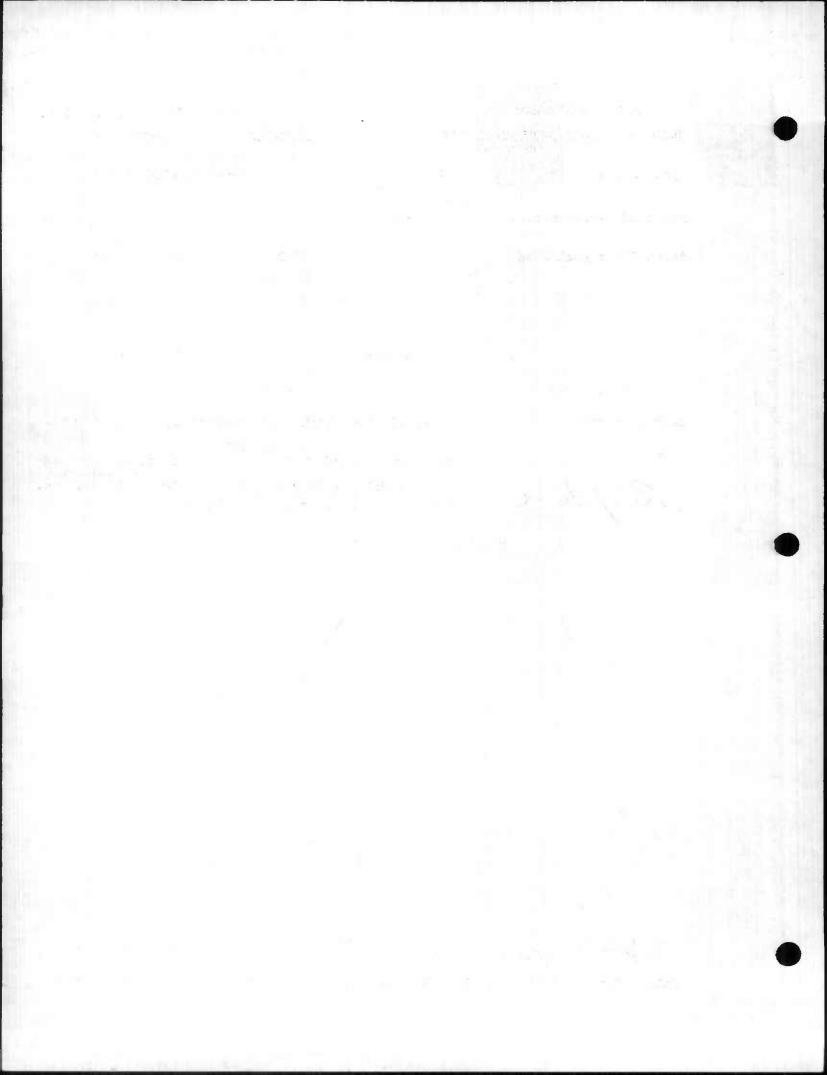
National Naval Medical Center, Bethesda, MD 20889

State Registrar 31. Date filed (Month, Dey, Yeer) **MAR 16**



30. Name and eddress of person wito completed cause of deeth (item 23e) (Type, Print)

John McCurley, LCDR, MC, WN



State of Maryland / Department of Health and Mental Hygiene Q 8

				Pertifica	te of l	Death	F	leg. No.) [1110
Physician	Decedent's Nama (First, Middla,						2. Data of Daa Month	th Day	Yaar	3. Tima of Death
/Medicai	FRE	D Me	cCOY				MARCH	16, 1	1998	4:45 PM
Examiner	4e. Fecility Nama (If not institution,	giva street and number)			4	b. City, Town, or	Location of Death	4c. County	of Death	
	GREENBELT	NURSING HOM	E			GREENBE	ELT	PR	INCE G	EORGES
unerai	5. Sociel Security Number		(In yrs. last birtho	lay) If Unda Months	r 1 Yaar Deys	If Under 24 Hrs Hours Min			-	oa (Stata or Forei
ector	247-32-6528 Usuel Rasidance of Decedent	1 MM 2□ F 69	9 Yrs	3.	Doys	Tiours Will	APRIL 4	, 1928	N.	CAROLINA
her must be notified at funeral Director	10a. Stata 10b. County	1	IOc. City, Town o	r Location					100	d. Inside City Limit
Director		E GEORGES		COLLEG	E PA	RK				1∭Yas 2□N
Plan I	10e. Street end Number			10f. Zi	p Code		1	log. Citizan of	Whet Countr	y?
<u>a</u>	5011 LAKEL	ND RD.				0740			J.S.A.	
Funeral	11. Marital Status	12. Wes Decedant Ev Armed Forces?	ar in U,S.	Wes Dace if Yes, spe	dent of Hi	ispenic Origin? (S n, Maxican, Puar	Specify Yas or No- to Rican, etc.)	14. Rad Bla	ce - Amaricei ck, Whita, at	
by F	1 Mover Marriad 2 Merrie 3 Widowed 4 Divorced	If Yas, Giva	WII	1 🗆 Yas	2 X No	Specify:		Specif		LACK
Completed	15. Decedant's	Education	16a. De	ecedant's Usu	al Occupa	ation		16b. Kind of B		
ple	(Specify only highast Elamentery/Secondary (0-12)	grade completed) Collega (1-4or 5+)	- In	ilva kind of we la. DO NOT u	ork dona d Isa retired	during most of wo	rking			
E O	12	College (1-401 5+)		CUST	ODIA	N		F	RIVATI	Ξ
Be	17. Fether's Nama (First, Middla, La	ist)				18. Mothar's Na	ma (First, Middla,	Maidan Sumen	na)	
70	UNI	NWOVI					UN	KNOWN		
	19a. Informant's Name/Reletionshi	(Type, Print)	19b. M	ailing Addres	s (Street e	and Number or R	ural Route Numbe	r, City or Town,	Steta, Zip C	Coda)
To	WILLIE SPRIGO	S/FRIEND	S	AME A	SI	TEM #10				
e de la composition della comp	20a. Method of Disposition		20b. Plece of Di	isposition (Ne	ma of	n)	Date	20c. Location	City or Tow	n, Stata
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any injury	21. Signeture of Funaral Service Li	cansaa		22. Name e	nd Addras	s of Facility				
60	20:20 CKM	MERICA	100091	CHAMPE	प्रद हा	TAGEM	OMES, P.A	DTITE	TATE	MD 007
physician and street the buriel-transit	Sequantially list conditions, if any, laeding to Immadiate ceusa. Entar Underlying Ceusa (Disaase or Injury	a. Dehyo b. Caresto	ADMA ue to (or as a con	of (the	phar	ynx		4	cars
the bu	Ceusa (Disaase or Injury thet initiated avants resulting in daath) Last	c. Du	a to (or es a con	sequance of):	:					
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s ici	Part II. Other significant conditions	contributing to death but r	not resulting in th	a undarlying	causa giva	an in Part I.	23b. Did to	pbacco uee co	ntribute to t	he cause of deat
y Physician/							12KY	es 2 No	3 Proba	bly 4 🗆 Unkno
d by							24a. Was a	in autopsy	24b. Ware	a autopsy findings
shou							perfor	med?	avail	able prior to pletion of ceuse
Completed								Y	of de	
ပြိ							1 🗆 Y	es 2 No.	10	Yas 2□ No
Be	25. Was cesa refarred to medicel axaminar?	Hospital:			Othe	. ()	eth (Check only or	na)		
Tuneral director, tion: To Be (1 Yas 2√ No	1 L Inpatient	2 ER/Outpa			4CJ Nursing F	loma 5 ☐ Rasida			
lon	27. Menner of Deeth 1 Natural 5 Panding	28e. Dete of Injury (Month, Day Y	(ear) 28b. Tim	ry	28c. Injury Work	.7	28d. Describa h	ow injury occur	red	
Medical Certification:	2 Accidant investiga 3 Sulcida 6 Could no 4 Homicide datermin	be on Discontinu	- At home, farm, Spacify)	M straat, factor		Yas 2□No	28f. Location (Si City or Town		per or Rural I	Pouta Number,
edical C	29e. Certifiar (Check only one) (Check only one)	Physician: To the best of maminar: On the besis of ax	camination and/o	eath occurred r Invastigation	at tha tim	e, dete end place pinion, daath occu	a, and dua to the curred at the time, d	euse(s) end me eta and place,	ennar as stat and dua to ti	ted. he cause(s)
E 2	29b. Signatura and titla of certifiar	and mannar stata	u.	29	c. Licansa	number	2	9d. Dete signe	d (Month De	av Year)
ō	1 1	-6,	MI	7	7 2	07/1	7	11	1 17	IBOC
	Mellen	Uson	MI	K	de	11260	X /	lavo	414	1778
	30. Nama and address of parson wh	o complated ceusa of daet				**			1	
	NORTON ELS	ON M.D.	6525	BELC	REST	RD., #2	08, HYAT	PSVILLE	, MD.	20782
State	31. Data filad (Month, Day, Year)	32 Registrar's	Signature	2.00						

DHMH 16 Ray 6/95

THE REPORT OF THE PARTY OF THE and the second second second second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day 1998 Month Mary June McGraw March 18, 3:23 AM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) May 7, 192 9. Birthplace (State or Foreign Country) Indiana 1 M 2 X F Days Hours 313-20-6298 72 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 Hollywood Avenue 20904 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 DWidowed 4 □ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Leasing Manager Apartment Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Omer G. Martin Martha A. Unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lynn S. Malloy 914 Hollywood Avenue, Silver Spring, MD (daughter) 20904 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/21/98 Alexandria, Virginia Metropolitan Crematory 21. Signatur of Funeral Servica Licansee Francis J. Collins Funeral 22. Name and Address of Facility 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) ailur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last CYChair G Due to (or as e consequence of): 12pertension Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vasioler 24b. Were autopsy findings eveiteble prior to completion of cause of deeth? 24a. Was an autopsy performed? Hegit Unemia 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one)

28c. Injury at Work?

15 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the ceuse(s) and manner stated.

29c. License number

1 Tes 2 No

D41105 WD

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Be Completed by

2

Funeral

Director

r than "natural", or items 23s or 28a-f ahow the Medical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examinat

Baltimore, Maryland 21215-0020

death with

sician and burial-transit The law requires that the death certificate be executed P.O. Box 68760, signed by the at the detached for Division of Vital Records,

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifical completely filled in by the funeral director, g

Physician/Medical Examiner Be Completed by

Certification: To

2

State Registrar

Medical

MAR 20 1998

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Doctor Drive Germanten MID 2087 E 19529 32. Registrer's Signature ulle Davidson

200H 31. Date fited (Month, Dey, Year)

1 ☐ Yes 2 ☐ MG

27. Manner of Death

1 Natural

2 Accident 3 Sulcide

4 Homicide

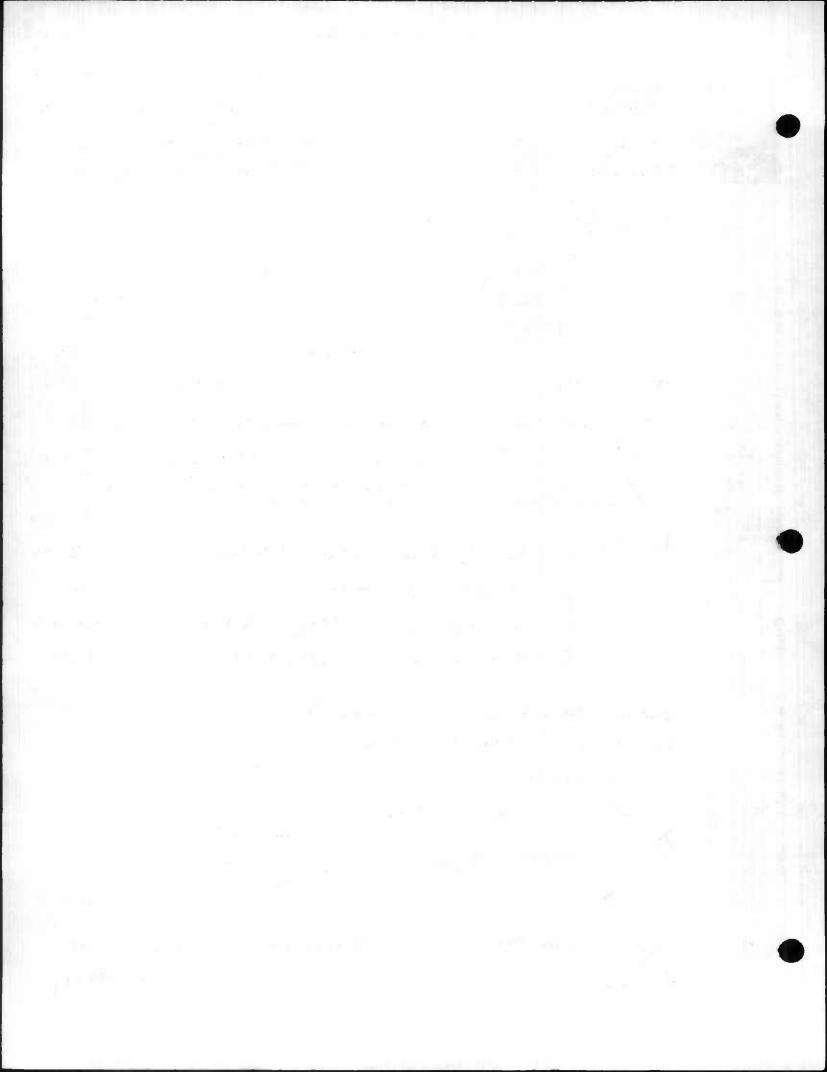
29b. Signature and title of certifier

29a. Certifier

1 Shpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Dev Month meeks 2340 P march 1998 13 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, giva street end number) 4c. County of Death ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY SHADY GROVE If Undar 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foraign Country) 6. Sex 1□M 2□F Days Months Hours 430-10-5241 July 24, 1906 Arkansas Usuel Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 19310 Club House Road, #601 20886 United States 14. Rece - American Indien, Bleck, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 Never Married 2 Merried 1□ Yes 2♥ No Specify: 3 ₩ Widowed 4 Divorced white 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) College (1-4or 5+) Executive Manager Newspaper 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Neme (First, Middle, Last) John Goacher Marion Bradlev 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 3241 "R" Street N.W., Dr. John Meeks, Washington, DC 20007 20a. Method of Diep sition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State Mar 19, 5 Other (Specify) 4 Donation 1998 Columbia Gardens Arlington, Virginia 21. Signeture of Funeral Service Licensee 22. Nama and Address of Fecility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877 for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Let only one ceuse on each line. 23e. Pert1. Enter the disease shock, or heart failure. Approximete Intervel Between Onset and Deeth Immediate Cause (Final Cerebro Vas cular acadent disease or condition resulting in deeth) Atrial Fibrill Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed' 1 Yes 1 Yes 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

g

Completed

7 is marked other than "natural", or flems 23a or 28a-f ahor traumatic avent, the Medical Examines must be noutled at

of the first of th

th and Mental Hygie 7 is marked other t

permit. Pages 1 and 2 should be t Department of Health and Mental I Important: If Item 27 Is marked of any Injury or other traumatic ave

Baltimore, Maryland 21215-0020

with the Maryland

deeth

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a peen: page 2 : certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician/Medical ð Completed Be L_o Certification:

edicai

29a, Certifier

Examiner

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth

5 Pending invastigation Natural 2 Accident 3 Suicida 6 Could not be determined 4 T Homicide

28e. Dete of Injury (Month, Dey Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner stated. 29b. Signeture and title of certifier

29c. License number D 45843 29d. Dete signed (Month, Day, Year)

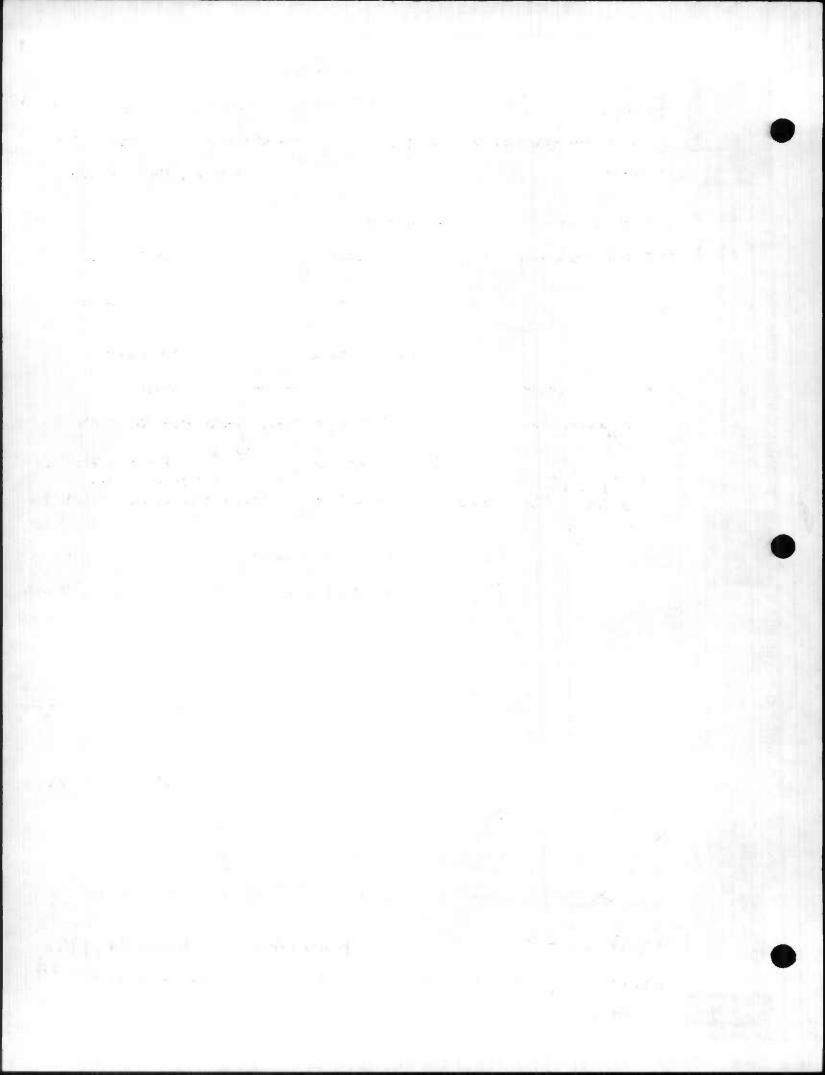
30. Name and address of person who completed cause of deeth (Hem 23e) (Type, Print)

N MA FILL ALY ASI N. Frederick Ave. #230 Garthersburg

31. Dete filed (Month, Dey, Yeer) MAR 18 1998

3) Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month ELIZABETH MARCH 13 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number, SUBURBAN HOSPITAL BETHESDA MONTGOMERY 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Sacurity Number Birthplaca (State or Foreign Country) 6. Sax 1□ M 25 F Yrs. 163-28-0587 SEPT.30,1920 HUNGARY Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 X Yas 2 □ No MD. MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20814 U.S.A. 10210 FLEMING AVE. 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1 ☐ Yas 2 No If Yas, Giva Yaar or Dates: 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Spacify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) AT HOME HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) ISTVAN SEDONY ETELKA **VRANYA** 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MIHALYI/HUSBAND ELEMER ITEM #10 SAME AS 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/17/98 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signatura of Funarai Sarvice Lin 22. Nama and Addrass of Facility SILVER SPRING, MD. MINULUL MO0091 CHAMBERS FUNERAL HOMES, P.A. 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in death) . DISECTION OF AORTA 10 HRS MULTIPLE Dua to (or as a consequanca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably ∮ Unknown 24b. Wera autopsy findings available prior to complation of ceusa of deeth? 24a. Was an autopsy parformed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

attending physician and for use es the buriel-transit

certificate

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Hospital (24 hours e Funerel D

To the Hosp within 24 hor To the Fune completely fi

funeral

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Completed

Be

Certification:

Medical

certificate be

Records, P.O. Box 68760

Division of Vital

Physician

/Medical

Examiner

Director

à

Completed

Funeral

Director

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiane. Important: If item 27 la merked other than "naturel", or item any injury or other traumatic event

Saltimore, Maryland 21215-0020

the Maryland

Examiner Sequantially list conditions, if any, leading to Immadiata cause. Enter Underlying Causa (Diseasa or Injury that initiated events rasulting in daath) Last Physician/Medicai

27. Mannar of Death

1 Natural

2 Accidant 3 Suicida

4 Homicide

25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Yas 2□ No

28h Time of 28a. Data of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yas 28d. Dascribe how injury occurred

MOTOR VECHILE ACCIDENT 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

288. Date (Month, Day Year, MAR 13 98 NOON
28e. Plece of Injury - At home, farm, straet, fectory, office building, atc. (Specify)

TREET 29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and menner as steted.

5 Panding invastigation

6 Could not be detarmined

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Nama and address of person who complated cause of death (tiem (3a) (Type, Print)

10215 FERNWOOD RD BETHESDA MD 20817 MAYLE RANCIS 31. Date filed (Month, Day, Yaar) MAR 18 1998

State Registrar

As the first than the second of the second second OF BOAT TOWN STATES THOSE AND AND AND

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month RCH 12 MILES 1998 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL If Under 1 Year ROCKVILLE
If Under 24 Hrs. 8. Da ADVENTIST MONTGOMERY 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) Min. Months Days Hours 1⊠M 2□ F

Funeral Director

Physician

/Medical

Examiner

28a-f show Directo Funeral þ Completed

with the Marylend 7 is marked other than "natural", or items 23s or 28s-f shov traumstic event, the Modical Examinat must be notified at permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mantel Hygiene. Important: if fem 27 is marked other than "natural", or thems 23 any Injury or other traumatic event, the section for many injury or other traumatic event, the section for man

Baltimore, Maryland 21215-0020

Physician /Medical Examine

or Attending Physician: The law requires that the deeth certificate be axecuted attending physician end for use es the burial-transit Division of Vital Records, P.O. Box 68760, the signed by t peed Sec cartificate director, this Aftar thi death. Hospitai

Examiner Physician/Medical þ Completed Be Certification: To n 24 hours efter death.

The Funeral Director: A pletely filled in by the fi edical To the I within 2 121

1. Decedent's Name (First, Middle, Last) HOM AS 4a Facility Name (If not institution, give street end number) SHADY GROVE 8. Date of Birth (Month, Dey, Yeer) Sept. 25, 1911 5. Social Security Number 86 579-22-8743 Maryland Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Tes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 14213 Hi-Wood Drive 20850 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 1 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White Yeer or Dates: WW II 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Telephone Company Installer/Repairman 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Della King Howard Montgomery Miles 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 14213 Hi-Wood Drive, Rockville, Maryland Janet E. Miles/Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Monocacy Cemetery March 16, 1998 Beallsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Robert A. Fumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximete Interval Between Onset and Death Immediate Cause (Final 2 years LUNG CANCER disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequenca of):

27. Menger of Deeth

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1□ Yes 2☑ No 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of fnjury (Month, Dey Year) 5 Pending investigation 6 Could not be determined

28b. Time of 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Place of Death (Check only one)

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Year)

24a. Was an autopsy performed?

1 Yes 2 No

28d. Describe how injury occurred

29b. Signature and title of cartifier

March 13,1998

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings aveileble prior to

completion of cause of death?

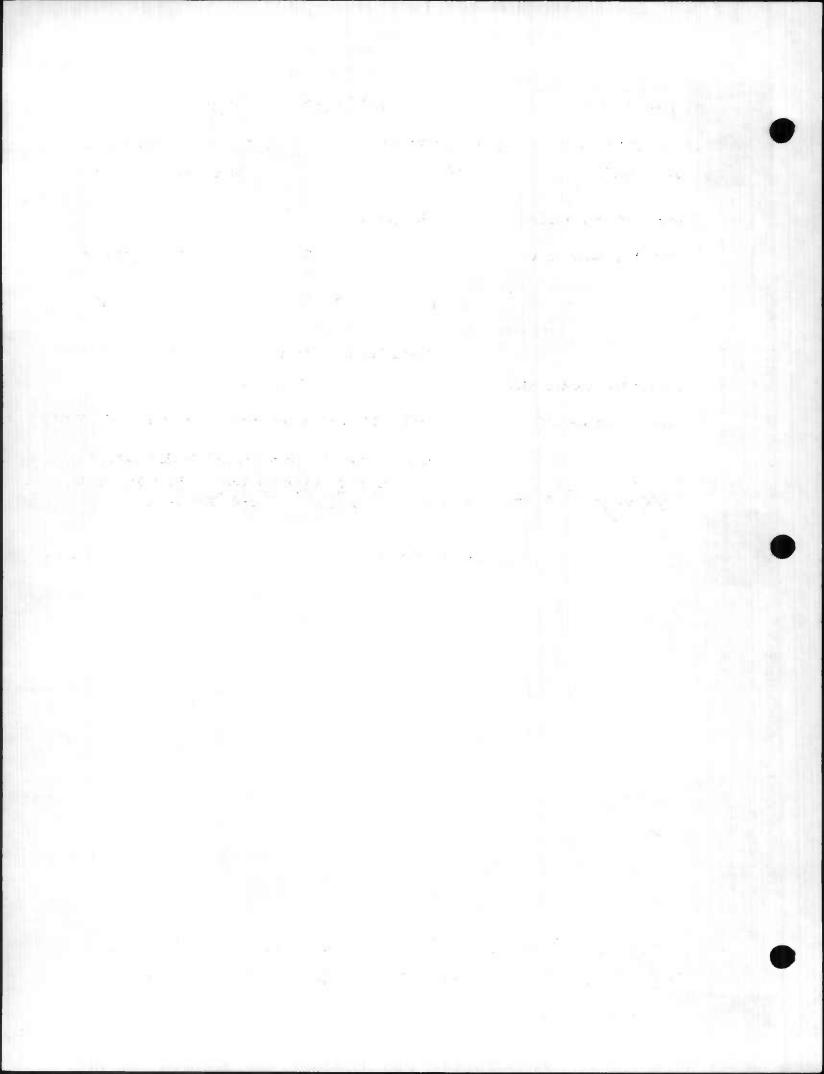
1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 809 Veirs Will HOLDEN

31. Date filed (Month, Day, Year)

Kuckville 32 Registrar's Signature ifia Davidson Randelle

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:30 PM Veronica M. Miller 11, 1998 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21 Old Creek Court Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2⊠ F November 9, Yrs. 485-36-4825 62 Iowa Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Old Creek Court 20854 United States 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Tes 2 No Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Interior Designer Harrison Interiors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Eugene McMullen Mary Eblen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) F. Harrison Miller/ Husband 21 Old Creek Court Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, cramatory or other place) March 13, 1998 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 21. Signature of Funeral Service Licensee M00831 Dar Dava 300 Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest 1 Hour Dua to (or as a consaquence of) Advanced Metastatic Lung Cancer Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Hypercoagulable State Due to (or as a consequance of). Anemia Part II. Other algrifficant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1⊠ Yes 2 No 3 Probably 4 Unknown Deep Venous Thrombosis, Chronic Obstructive Pulmonary 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Disease completion of ceuse of death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☑ No 25. Was cesa raferred to medical 28. Placa of Death (Check only one) Othar: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 8 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year)

D39190

March 12, 1998

Division of Vital

The law requires that the death certificate be executed the burial-transit end Records, P.O. Box 68760. physiclan USB as signed by the aid be detached for peen certificate Attending Physician: spital or Attending Physhours effer death.
neral Director: After this y filled in by the funeral di this To the Hospital o within 24 hours of To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

must be notified at

Director

Funeral

by

Completed

Be

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental Hygiene. Important: If than 27 is marked other than "any Injury or other traument."

Physician /Medical

Examiner

Physician/Medical

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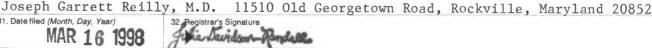
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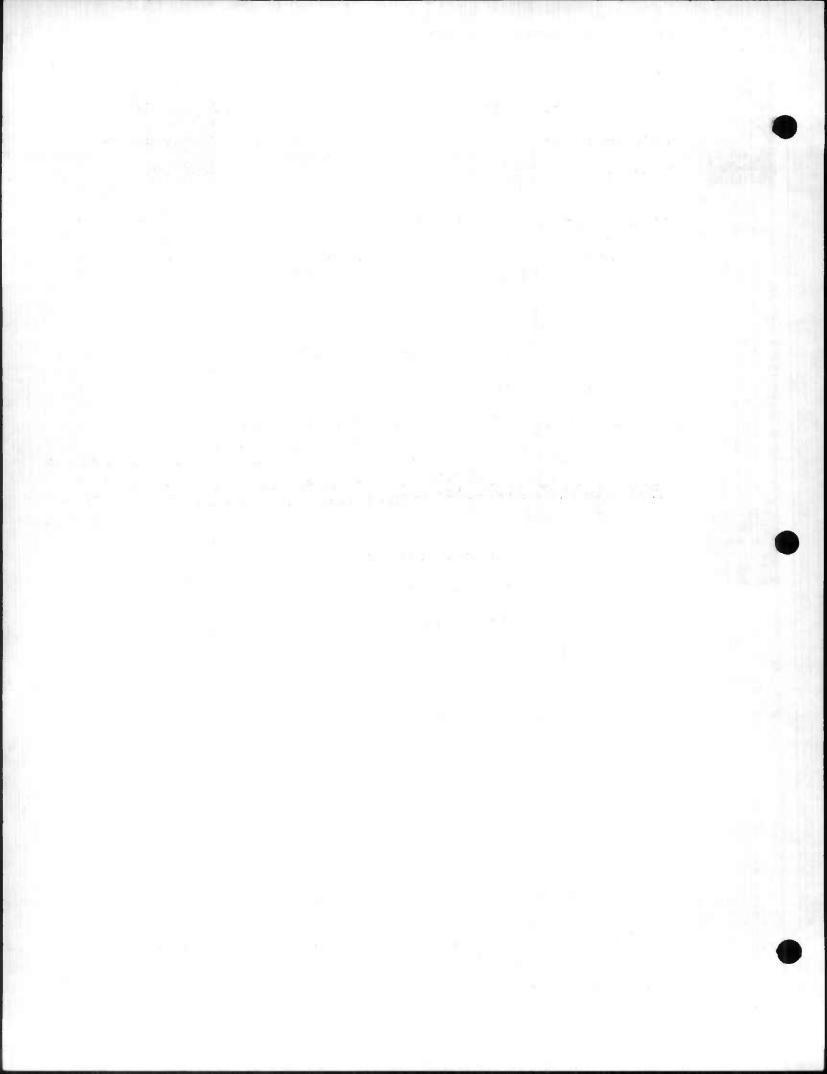
State Registra

31. Date filed (Month, Day, Yaar) MAR 16 1998

30. Name and addrass of person who complated



ause of daath (Itam 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month March 18, 8:00 AM Herbert Henry Moeller 1998 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth 317 Gruenther Avenue Rockville Montgomery If Under 24 Hrs. Note of Birth (Month, Dey, Year)
Oct. 27, 1905

| Sinthplece (Stere of Country) | Properties of Country) | Oct. 27, 1905 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys 1⊠M 2□ F 92 Yrs. 044-07-7886 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director MD Rockville Montgomery 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 317 Gruenther Avenue 20851 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Electrician Electrical 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Bertha Mohring Gustav Moeller 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joan A. O'Brien (daughter) 13305 Ardennes Avenue, Rockville, MD 20851 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 St Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Riverside Cemetery 3/21/98 Norwalk, Connecticut 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Servica Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 DIMOS. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, if heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel Cardiac Arrest Immediate diseese or condition resulting in death) Due to (or es e consequence of): Examiner Coronary Atheroscerosis Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medicai Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Bed confined due to dementia þ 24b. Were eutopsy findings eveileble prior to completion of cause 24e. Wes an autopsy performed? Inability to swallow due to strokes of deeth?

Physician /Medical Examiner

ed by the attending physician and datached for usa as the bunal-transit the death certificate be executed

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Completed

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Certification: To

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Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

the Maryland

with

72 hours after death

at Hygiene.

12 should be fi and Mental H

permit. Pages 1 and 2 st Department of Haalth and Important: If item 27 ie m any injury or other traum

Maryland 21215-0020

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify)

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 5 Pending

investigation 2 Accident 6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 Yes 2 No

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

1 Tyes 2 No

28d. Describe how Injury occurred

(Check only one) 29b. Signeture end title of cartifier

₽9c. License number

1 ☐ Yes 2 ☐ No

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Richard P. Delaney, M.D. 9801 Georgia Avenue, Silver Spring, MD 31. Dete filed (Month, Dey, Yeer)

State Registrar

MAR



DHMH 16 Rev 6/95

The law requires of Vital Physician:

Box 68760,

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Records.

funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral

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29a. Certifier

3 ☐ Suicide 4 Homicide

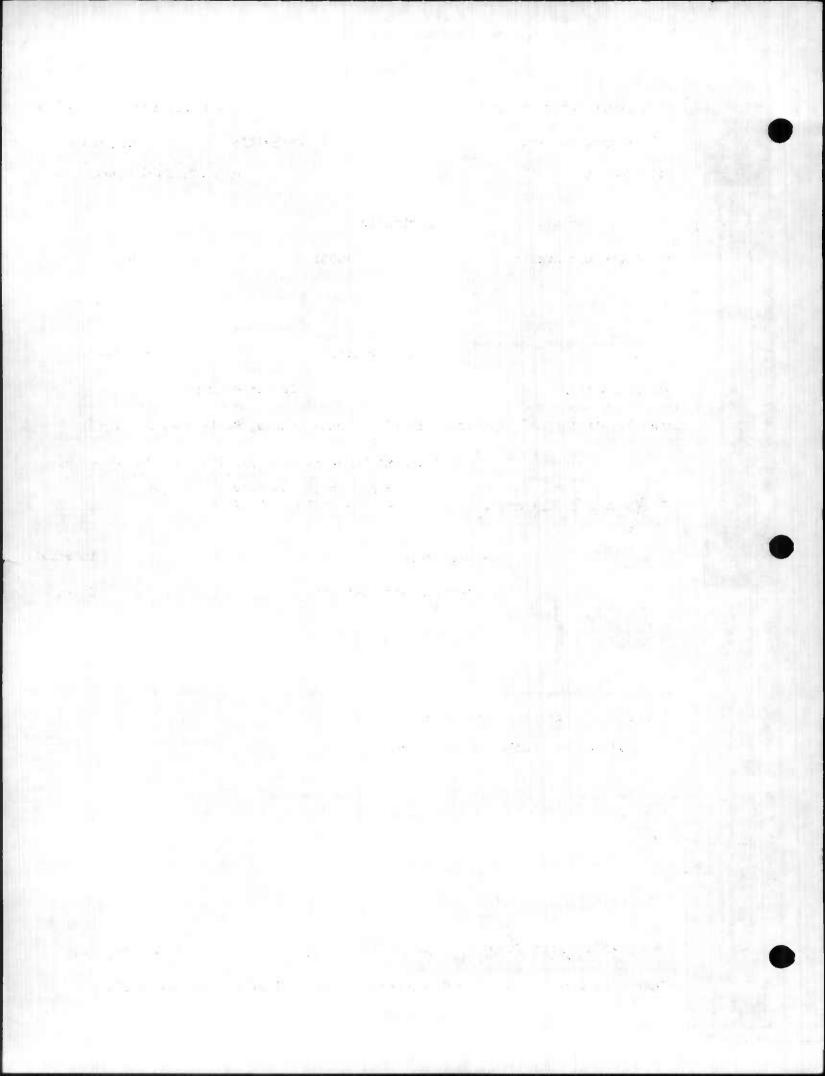
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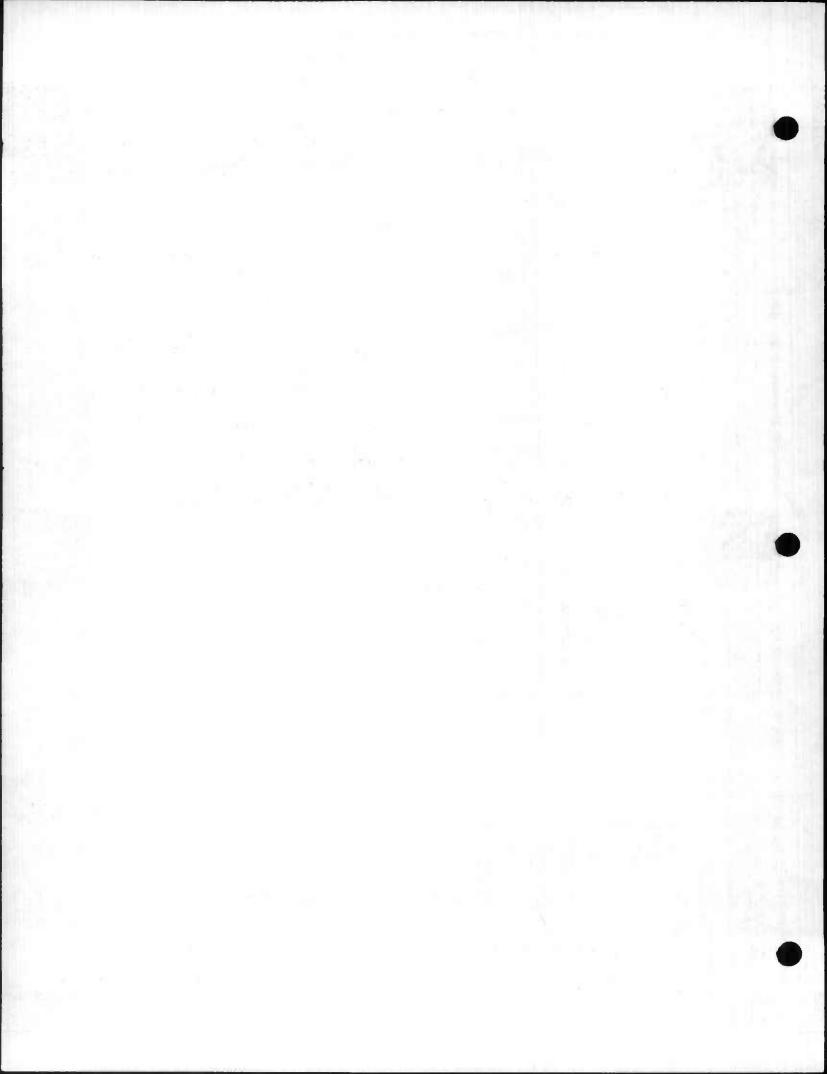
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March 18, 1998



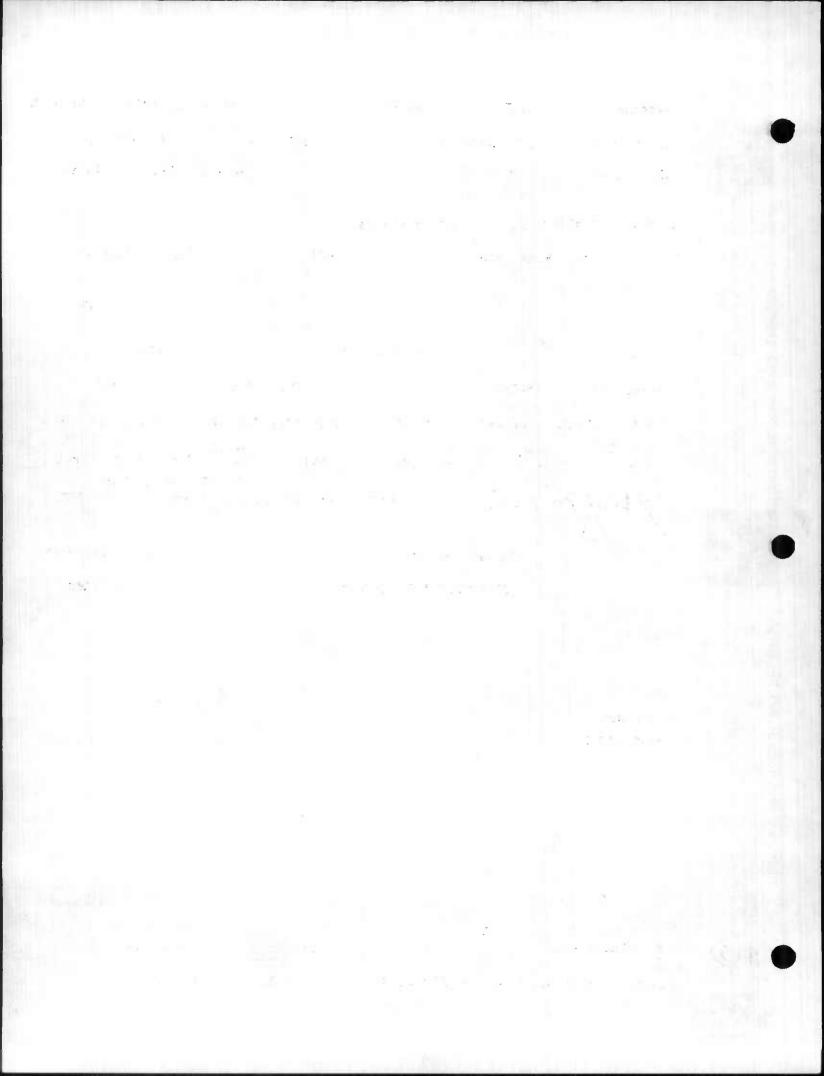
				State of Mai	ryland	-	artment of F tificate of		nd Men		giene) {	3 10	123
	Physici /Medi		1. Decedant's Nama (First, Middla, La Ar	™ nita Ann Moo	ore-A	gwatu				Data of Daa Month arch	18, 199	Yaar	:45 AM
,	Examir		4e. Feolity Neme (If not Institution, git 3023 Crest Avenu	va street and number)				46. City, Town Cheve		on of Death	7	of Death	e's
	Funeral Director			Sax 7. Age 1 1 M 25√F	(In yrs. lest 45	birthday) Yrs.	If Under 1 Year Months Days	If Undar 24 Hours	Min. (Deta of Birth Month, Day By 11.	Year) 1952	Country)	state or Foreign
	e Maryland ta-f show	ctor	10a. Stata	1	10c. City, T Was		ton, DC						side City Limits
	h with th	al Director	10e. Street end Number 6119 Clay Street	. NE			10f. Zip Coda 20019				og. Chizen of V United		
yland 21215-0020 ould be filed within 72 hours after death with the Manyland Mental Hyglene. arked other than "naturel", or items 23s or 28s-f show atte event, the Medical Examiner must be notified at		by Funeral	11. Marital Stetus 1 Navar Married 2 Married 3 Widowad 4 🔯 Divorced	12. Was Decedent Ev Armed Forcas? 1 Yes 2 No If Yas, Giva Yaar or Dates:	edent Ever In U,S. orcas? 2X\in No va 13. Was Decedant of H If Yas, specify Cuba 1 \sum Yas 2 \sum No		Hispenic Origin? (Specify Yes or No- en, Maxicen, Puarto Rican, atc.) Specify:			14. Rac Blac	14. Race - American Indian, Black, Whita, atc.		
Maryland 21215-0020	d within 72 ho giene. r than "natur the Medical	Completed		(Specify only highast grada complated) Elementary/Secondery (0-12) College (1-4or 5+)			ie. Decedant's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired) Secretary			16b. Kind of Businass/Indus		usinass/industry	
ryland	should be file and Mental Hy marked othe umatic event,	To Be C	17. Fathar's Nama (First, Middla, Last) Unavailable Pathe 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Inc.)				nelia	Loui		re			
re, Marylis 1 and 2 should fileath and Mer tem 27 is marke other traumatic			Lisa D. Moore /	daughter	3	3023	ng Address (Street Crest Ave sition (Nama of natory or other pla	enue, (Chever		D 2078	_	
baitimore,	permit. Peges 1 and 2 Depertment of Health e Important: If Item 27 is any injury or other tra 900.08.		1 ☐ Burial 2 ☼ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	fy)		apeak	ce Cremat Nama and Addra 1pp Funer	ory	3-19	9-98	Beltsvi A.	lle, Ma	ryland
	Physician /Medical Examiner		23a. Pan1. Entar tha disaasa, or com shock, or haart failure. List only Immediata Causa (Final disaasa or condition	oplications thet caused the ona causa on each line.	na daath. [93	33 Gist A	venue,	Silve	er Sp	ring, M	Appr	oximata val Batween at and Death
		Examiner	resulting in deeth)	HIV Infe	ua to (or as		uance of):						
0x 68/60,	the death certificate be executed by the attending physician end eched for use as the burlet-transit	edicai	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated avents rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
P.O. BOX	v requires that the death certifi been signed by the attending should be deteched for use as	Physician/M	Part II. Other significant conditions of	contributing to death but	not rasultin	g in tha u	ndarlying ceuse giv	ven in Part I.			obacco uae cor ree 2 No		cause of death?
Records,	law requires that es been signed b 2 should be det	Completed by								24a. Was e perfor		avallable	ion of causa
VII A	The ats h		25. Was cesa referred to medical					OC Disco	f Death (Ch	1 🗆 Y		1 □ Yas	2 No
5	5 00	To Be	examinar? 1 ☐ Yas 2 ☒ No 27. Mannar of Death	Hospitel: 1 Inpatient	28	/Outpetien	t 3 DOA Oth	nar: 4 □ Nurs		5 🗆 Rasid	ance 6 Doth	er (Specify)	ghter's Home
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		Certification:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b datermined	e one Diese of Indian	- At homa	Injury	M 1 🗆	rk? Yas 2⊡No	28f. L	ocation (S City or Tow		er or Rural Rou	ta Number,
	he Hospitu in 24 hours be Funera pletely fille	edical C	29a. Certifier 1 Certifying Pr (Check only 2 Medical Examone)	nyalcian: To the best of r ningr: On the basis of en end mennar state	kaminetion	dga, daath and/or inv	occurred et the tir eastigation, in my o	me, date and popular	place, and o occurred at	lua to tha c tha tima, d	ausa(s) and ma lata and place,	nner as steted. and due to tha c	euse(s)
	Vithii To th	M	29b. Signature and filla of certifier				29c. Licans D199	89				d (Month, Day, 18, 1998	
	Sta	ite	30. Nama and add fets of person to Gary L. Vilmon, M. 31. Data filed (Month, Day, Year)		Penn	sylva	Print) #5-41 Ania Aven		, Was	hingt	on, DC	20037-	2396

DHMH 16 Rev 6/95



	State of Maryland / Department of Health and Me Certificate of Death	Reg. No. 98	10124
Physician /Medical	Decedent's Name (First, Middle, Last) LORRAINE VALERIA MOSCHETTO	2. Date of Death Month Dey MARCH 15, 1998	3. Time of Deeth 8:55 PM
Examiner	4e Fecility Name (If not Institution, give street and number) MARINER HEALTH CARE OF BETHESDA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min.	MONTGO	MERY Birtholace (State or Foreign
Director	Usual Residence of Decedent	June 29, 1915 I	Compy) Ilinois
or 28e-f show be notified at Director	Maryland Montgomery Gaithersburg		10d. Inside City Limits 1 √ Yes 2 □ No
23a or 2	10e. Streel and Number 10f. Zip Code 20877	10g. Citizen of When	
or name to thems to the manner or the form of the part	11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto Forces) 1 □ Yes 2 ☑ No Specify:	Ricen, etc.) Black, V	Americen Indien, Vhite, etc. White
yglene. Net than "natura It, the Wedical Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) Bookkeeper	16b. Kind of Busine	ess/Industry
To marked other than ". The marked other than ". To Be Comple	17. Father's Ne <i>me (First, Middle, Last)</i> (Unknown) Thelan Christi		
of realth end f item 27 is my r other treum	19a. Informant's Neme/Relationship (Type, Print) Albert Moschetto, husband 66 W. Deer Park Rd., #1	Ol Gaithersburg	, MD 20877
Department of Health Important: If Item 27 any injury or other tr once.	4□Donation 5□Other (Specify)/ Metropolitan Crematory 19	pare 16, Alexandri	a, Virginia
Impor	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10 E. Deer Park Dr.		MD 20877
ysician Medicai	23e. Part. Enter the diverse, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final	r respiratory srrest,	Approximate Interval Between Onset and Death
caminer	disease or condition resulting in death) CARDIAC ARREST Due to (or as a consequence of):		IMMEDIATE YEARS
ettending physician end of or use as the burial-transit iclan/Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury Ihat initiated events resulting in deeth) Lest CARDIOVASCULAR DISEASE Due to (or as a consequence of): c		IEARS
ys the	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contril	
b sq	ALZHEIMERS HYPERTENSION		Probably 4 Unknown Were sutopsy findings available prior to completion of cause of death?
certificate has been s rector, page 2 should Be Completed		1□ Yes 2☒No	1 ☐ Yes 2 ☐ No
fler this cert ineral direct on: To B		ne 5 Residence 6 Other (28d. Describe how Injury occurred	Specify)
in by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number of City or Town, State)	or Rural Route Number,
To the Funeral Completely filled	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and place, a 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred and menner stated.	ed at the time, dete end place, end	due to the cause(s)
3	29b. Signature and title of certifier 29c. License number D28135	29d. Dale signed (A MARCH 16,	
	30. Name and address of person who completed cause of death (item 23a) (Type, Print) DONNA RINIS, M.D., 6000 EXECUTIVE BLVD., #300 ROCKVII	LLE, MD 20852	
State Registrar	31. Date files Arout, Pars Years 98		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day 1998 Year March 14, 2:00 AM Lucille A. Mulkey 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Bethesda Bethesda Montgomery If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Days Hours 1 M 2 X F Yrs 99 10, 1898 South Carolina 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Bethesda 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 4857 Battery Lane #506 20814 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Beauty Shop Hairdresser 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charley Sexton Myri Gaffney 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4857 Battery Lane #506, Bethesda, Maryland 20814 Clemie W. Sexton/Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) March 16, 1998 20c. Location - City or Town, State 1 ☐ Burlal 2 ☑ Cremation 3 ☐ Removal from State ROBERT And Address of Facility of Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 21. Signature of Funeral Service Licensee and M00198 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart ailure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Congestive Heart Failure 2 months Due to (or es a consequence of): Coronary Artery Disease Due to (or as e consequence of): Non Q wave Myocardial Infarction 2 months Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an eutopsy performed? 1 ☐ Yes 21 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) and manner stated.

29c. License number

D01948

29d. Date signed (Month, Day, Year)

20814

March 16, 1998

Box 68760 P.O. Records, Division of Vital

that the death certificete be executed

The law requires

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

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Completed

Be

7 is marked other than "natural", or items 23a or 28a-f sho traumstic event, the Medical Examiner must be notified at

12 should be filed within 72 hours after and Mentel Hygiene.
Is marked other than "natural", or ite

permit. Pages 1 end 2 si Department of Health en Important if Nem 27 is r any injury or other traus

Physician /Medical

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has page 2

certificate

al or Attending Physician: T s efter deeth. Il Director: After this certificat od in by the funeral director, pa

Examiner

Physiclan/Medical

p

Be Completed

Certification: To

Medical

Baltimore, Maryland 21215-0020

the Meryland

5. Social Security Number

244-18-2961

Maryland

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

1 Yes 2 No

27. Manner of Deeth

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of pertition

disease or condition resulting in death)

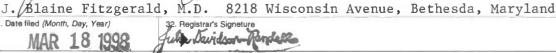
10a, State

Usual Residence of Decedent

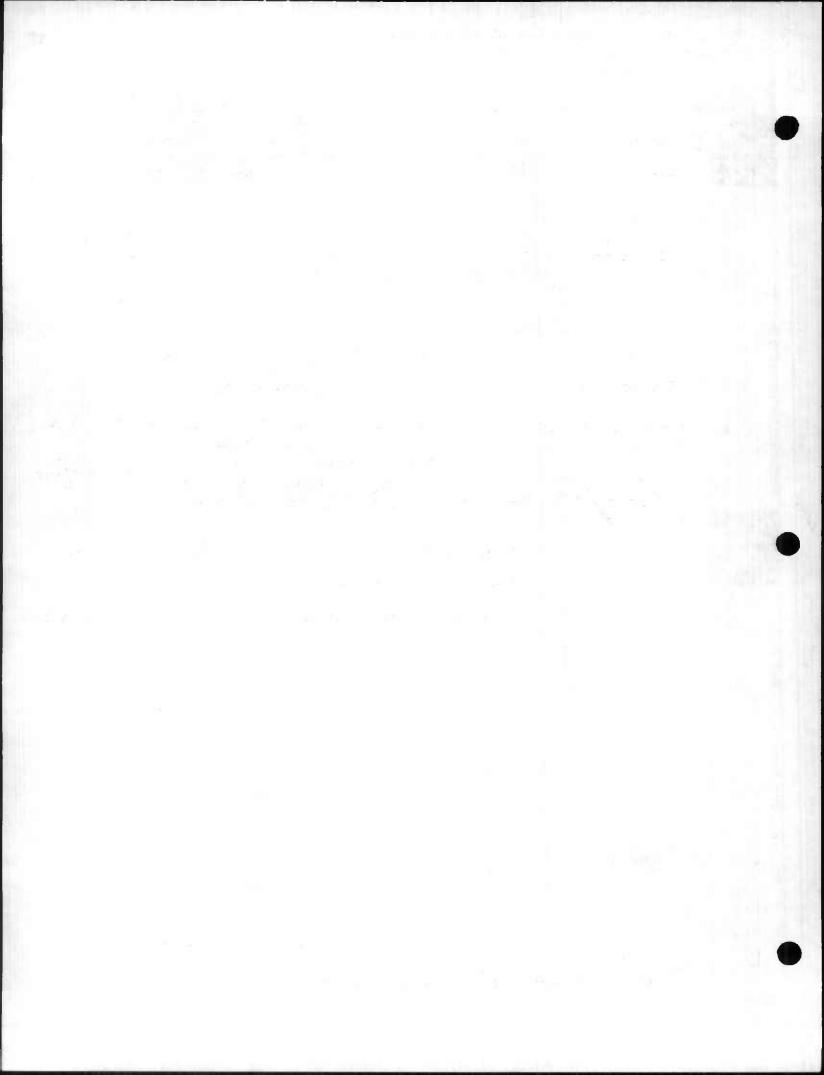
To the Hospital o within 24 hours eff To the Funeral Di completely filled Ir iΰ

State Registrar

31. Date filed (Month, Day, Year) 18 1998 MAR



30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)



Page 6 may be retained by the hospital or attending physician. If director, page 5 should be detached for use as the burla-transit MORE, MARYLAND 21203-3146

notified at

BY

COMPLETED

BE

5

permit. Pages 1, 2, 3 should

BALTIMORE, MARY	hours after death. Page 6 may be retained	ed in by the funeral director, page 5 should or removal.	medical examiner must be notified
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained	TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should have also ween 70 hours shar death with the State Deat of Health and Mental Hydiane prior in burial cremation or removal.	IMPORTANT. It tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified
	TO THE HOSF	TO THE FUNE	IMPORTANT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATN 3. TIME OF DEATN I O MONTH 0700 A M Beatrice F. Markle 4 SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 5 SEY IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign MONTHS DAYS HOURS MIN. 1 M 2 J/F YRS. 179-07-1184 87 June 8,1910 PA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 1028 Cherrytown Rd. Westminster Carrol1 RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 10a. STATE MD Carrol1 Westminster 1 YES 2 NO 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 101, ZIP CODE 1028 Cherrytown Rd. 21157 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, etc. FORCES? 1 YES 2 If yes, specify Cuben, Mexican, Puerto Rican, atc.)

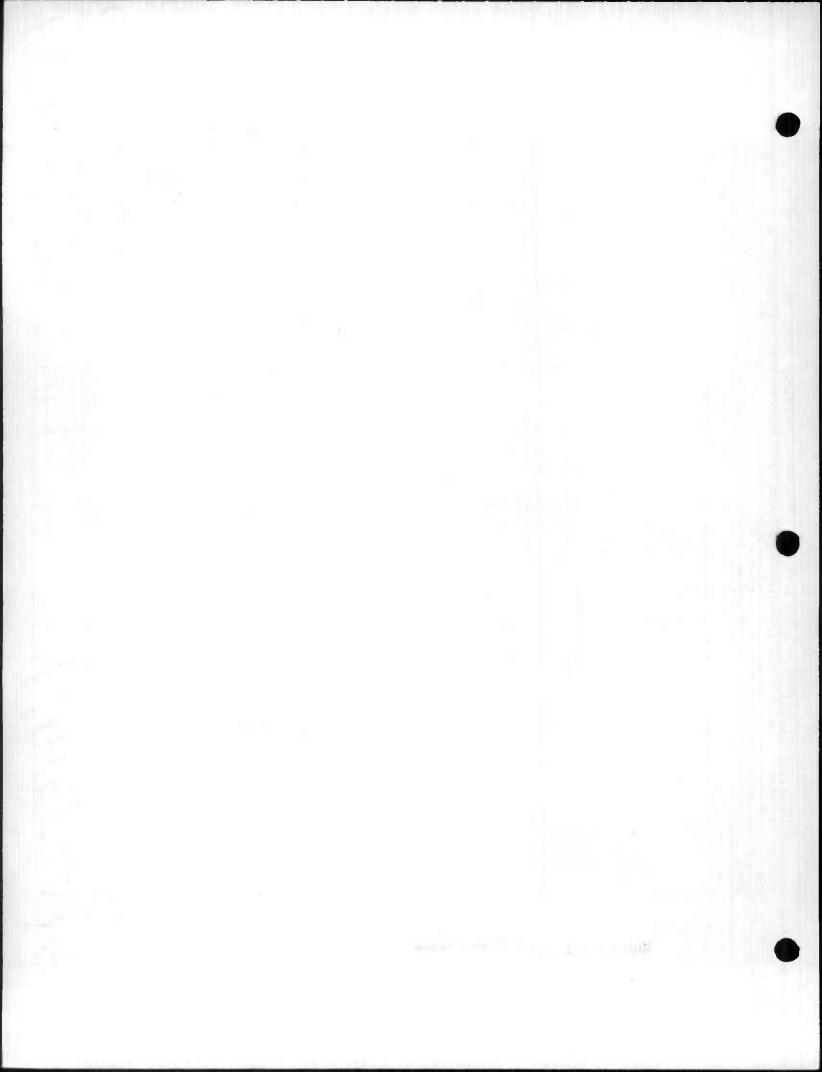
1 YES 2 NO Specify: 1 Never Married 2 Married White BY 3 Wildowed 4 Divorced ETED t6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 185 KIND OF BUSINESS/INDUSTRY ast of working Elementary/Secondary (0-12) College (1-4 or 8+) COMPL 10 Machinist Shoe Factory 17. FATHER'S NAME (First Middle Lest) 16. MOTNER'S NAME (First, Middle, Malden Surname) Maurice Fleming Mabel Leightner BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1028 Cherrytown Rd. Westminster. MD21157 Nancy Flickinger Daughter 20e. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE OF DISPOSITION (Name of cometery, crematory or 20c. LOCATION -- City or Town, State Rest Haven Cemetery 3/13/98 Hanover, PA 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY enna Littles'F.H.34 Maple Ave.Littlestown, PA17340 23. PART I. Enter the disesses, or complications that caused the death Do not enter tha mode of dying, such as cardiac or respiratory arrest, Interval Batween shock, or heart failure. List only one ceuse on each line Onset and Death IMMEDIATE CAUSE (Final tastatic colon disease or condition resulting in death) year Cancer me DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24e. WAS AN AUTOPSY MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 - YES 2 700 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE QF DEATN (Check only one) EXAMINER? OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 - Other (Specify) 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED

26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 29e. CERTIFIER
(Check only)

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the ition end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

m70396461

Afores		MD039646L	•	3-10-98
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)				
Satish A. Shah, M.D. 1030 Fairfield	Rd	Gettysburg.	PA	17325
31. DATE FILED (MONTH), Day, Year) MAR 1 2 1998 Julia Dauber Carball	,	, , , , , , , , , , , , , , , , , , , ,		
1040				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical
Examiner

Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglena. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be inclined as

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

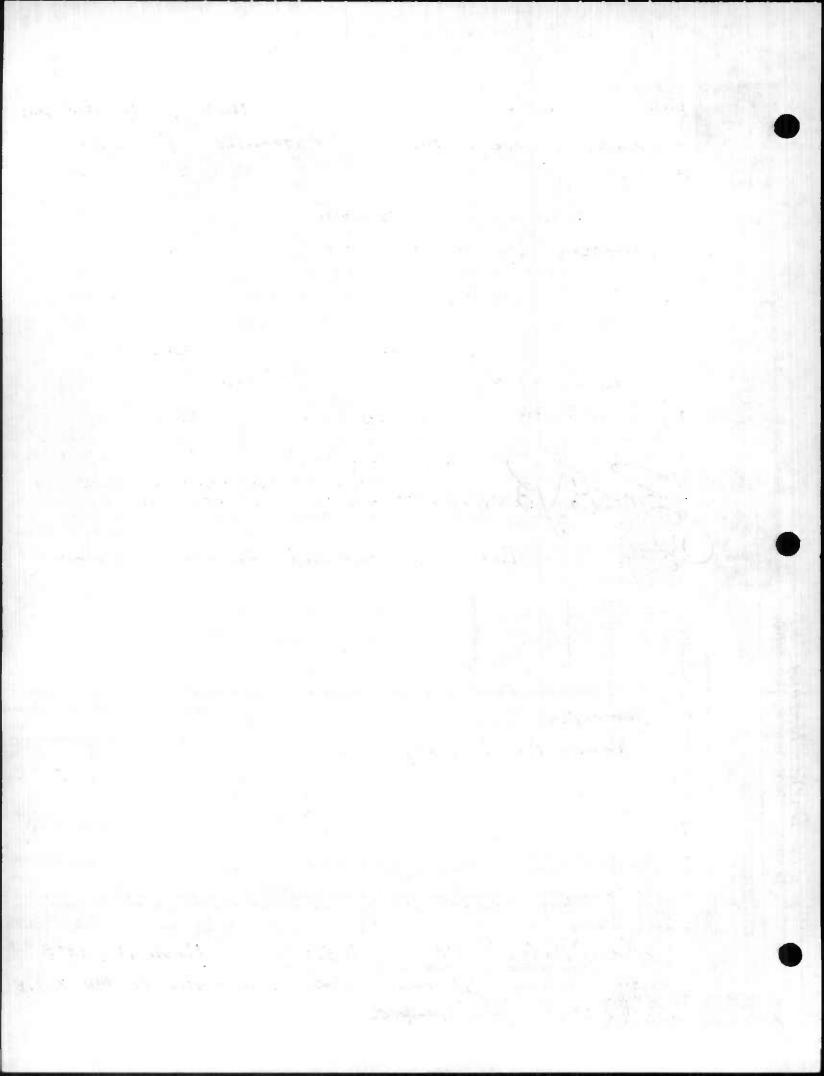
or Attending Physician: The law requires that the death certificate be exe Name David Meeney Division of Vital Records, P.O. Box 68760,

settlicate has been signed by the attending physician and rector, page 2 should be detached for use as the burist-transit To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors.

Decedent's Nama (First, Middla, Las							2. Data of Dea	Davis		3. Time of Death
David H. Mooney	, Jr.						March	Day	98	1:20 0
4a. Facility Nama (If not institution, give	street and number)			4	b. City, Tow	n, or Loc	ation of Daath	4c. Coun	ty of Death	
Charlestown	Care	Center			Cat	mi	ille	Ba	1.ton	noxe
5. Social Sacurity Number 6. Se	ax 7. Age	a (In yrs. last birth	hday) If Unda	ar 1 Yaar	If Undar 2	4 Hrs.	Date of Birt	h		nplaca (Stata or Fora
250-42-1825	M 2□ F	71 Y	rs. Months	s Days	Hours	Min.	Jan 25,	1927		uth Caroli
Usuel Residance of Decedant										
MD Balt	imore	10c. City, Town		7	7 -				i	10d. Insida City Lim
	Illore		Cator	nsvil	re					1 □ Yas 2🔀
10e. Street and Number 709 Maiden Choice	Ln, Rm: S	South 42		ip Code 21228				10g. Citizan of USA		untry?
11. Marital Status	12. Was Decedant E Armed Forces?	Evar in U,S.	13. Was Dece	edant of H	ispanic Orlgi in, Maxicen,	n? (Spec	ify Yas or No-		ice - Amar ack, Whita	rican Indian,
1 Navar Married 2 Married	1 ⊠ Yas 2 □ N If Yas, Giva	WWII	1 🗆 Yas		Specify:	- Guito I	iodii, dio.,	Speci	T 13	nite
3 ☑ Widowad 4 ☐ Divorced	Yaar or Datas:	MMTT			ороспу.			Speci	ny.	
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Elementery/Sacondery (0-12)	College (1-4or 5) +)	(Give kind of w lifa. DO NOT		1)			77	,	
	5-	+	Engine	er				Westin		6e
 Fathar's Nama (First, Middla, Last) David H. Mo 					18. Mother		First, Middla,	Maiden Sume	ma)	
19a. Informant's Name/Relationship (T. Janet Mooney/daug	ype, Print) hter		Mailing Addras							
					ningto	on 51	reet,	paitim	ore,	MD 21231
20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ I	Ramoval Iron State	20b. Place of I camatary	Disposition (Na r, cramatory or	ama <i>of</i> othar plac	a)	М	Date ar 17	20c. Location		
4 Donation 5 Other (Specify		MD Vet	erans (Cemet	ery		1998	Crowns	ville	e, MD
21. Signature of Fatheral Service/Libera	100		R 22. Nama a	and Addras	ss of Facility			one Dem	le Erre	neral Home
James Y. X	1211	ma						erna Pa		
				Illa Id	IK, I	MD 21146				
Peril. Inter the disease, or comp shock, or heart failure. List only	_		ot antar tha mo	oda of dyin	g, such as co	ardiac or	raspiratory are	rast,		Approximeta Interval Batween Onsat and Daath
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State Registrar



r 25a-f show notified at b

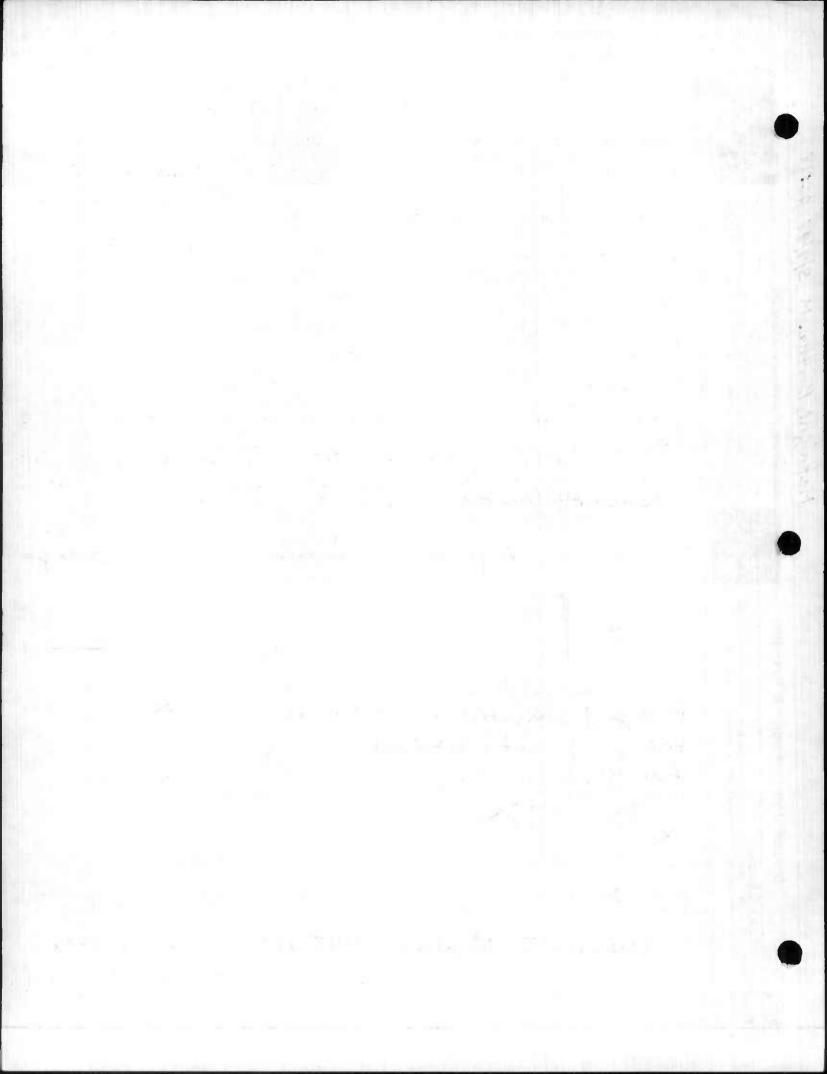
McKnight, Bartha.

that the deeth certificete be executed Box 68760, P.O. Records, Division of Vital

Certificate of Death 1. Decedent's Nama (First, Middle Last) 2. Data of Death 3. Tima of Deeth **Physician** Month Bertha McKnight March 7, 10:18 P.M. 1998 /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery County 5. Social Security Number if Undar 1 Year | if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 18, 1915 7. Age (In yrs. last birthday) **Funeral** 9. Birthplece (Stata or Foreign Country) Sharon, 1□ M 2X F Days Hours 210-05-8727 Yrs. 82 June Director Pennsylvania Usual Rasidance of Decedant 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Brookeville 1 Yes 2X No Maryland Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? United States the Medical Examiner must be 20833 "natural", or Items 23a 230 Haviland Mill Road of America 12. Was Dacedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No ff Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - Amarican indien, Black, Whita, atc. 1 □ Never Married 2 □ Married 1 Yas 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. KInd of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) and Mental Nicholas Zimmer Deborah Hughes 19a. fnformant's Name/Raietlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Important: If them 27 is any injury or other free Kathryn Gross /Daughter 230 Haviland Mill Road, Brookeville, Maryland 20833 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data ъ 1 Buriei 2 ☐ Cramation 3 ☐ Ramoval from Stete March Saint Rose Cemetery 4 Donation 5 Other (Specify) 12,1998 Hermitage, Pennsylvania 21. Signature of Funarai Sarvica Licansea #M00690 22. Name and Addrass of Facility McGonigle Funeral Home (ausa 1090 East State Street, Sharon, Pennsylvania 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarvai Batween Onsat and Death **Physician** /Medical Immediata Cause (Final disease or condition rasulting in death) Examiner ettending physicien and for use as the buriel-transit Sequentially list conditions, if eny, laading to immediate causa. Entar Undarlying Cousa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or es a consequança of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 5 1 Yes 25 No 3 Probably 4 Unknown signed b Be Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24e. Wes en autopsy performed? Anemia certificate 1 ☐ Yas 2 ☐ No al or Attanding Physician: Ti s efter death. il Director: After this certificat ed in by the funeral director, pe 25. Was case raferrad to medical 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manpar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Natural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and due to the ceusa(s) and mannar as stated.

2 Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mennar stated. 29a. Certifier Medical 29b. Signature and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and eddress of person who completed causa of death (Item 23e) (Type, Print) W. T. Ninala 1811 Punce Philli p Drive, Suite 212, Olney, 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State MAR 12 1998 Lulia Davidson Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()



				State of N	naryland /	Certificate of			giene 9 (8	0129
	Physic	ian	Decedent's Name (First, Middle					2. Date of De	eth Day	Year	3. Time of Death
J.	/Medi		William		William:	S		March	7 199		4:38AM
ار	Exami	ner	4a. Facility Name (If not institution		r)		4b. City, Town, or L	ocation of Death	4c. County	of Death	
L		М	61 Frankli			oidhdev) If Under 1 Ye	Annap				undel
	Funeral Director		5. Social Security Number 215-12-9099 Usual Residence of Dacedent	1 DXM 2 □ F	nge (In yrs. lest b 94	Yrs. Months Da		8. Date of Bird (Month, De Feb 28	y, Yeer) 1904		lace (State or Foreign try) York
	and w		10a. State 10b. County		10c. City, To	wn or Location		-		1	0d. Inside City Limits
	Mary 1 sh	ō	MD Anne	Arundel	A	nnapolis					XXYes 2□No
	the 28s	Director	10e. Street and Number			10f. Zip Cod	0		10g. Citizen of V	Vhet Coun	trv?
	h with		61 Frankli	n Street			21403		Uni	tod G	States
	deat	Funeral	11. Maritel Stetus	12. Was Deceden	t Ever in U,S.	13. Was Decedent	of Hispanic Origin? (Sp Juben, Mexicen, Puerto	ecify Yes or No		e · Americ	en Indien,
21215-0020	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show folice! Examinet must be routified at	by	1 Never Married 2 Marr 3 Widowed 4 Divorced	led 1 ☐ Yes 2 ☐ If Yes, Give 2 Yeer or Dates	No	1 ☐ Yes 2 ☐		Hican, etc.)	Specify	k, White, i	White
2-0	72 ho	ted	15. Decedent	's Educetion	16	a. Decedant's Usual Oc (Give kind of work do	cupation		16b. Kind of Bu	siness/inc	lustry
21	within 72 ho iana. ' than "natur the Medical	Completed	(Specify only highes Etamantary/Secondary (0-12)	College (1-4or		life. DO NOT use rei	tired)	ing			
121			12	5		Attorney			Law		
Maryland	8 ta 8 y	Be	17. Father's Name (First, Middle,	,			16. Mothar's Nam	e (First, Middle,	Meiden Sumem	e)	
Z	d 2 should th and Men 7 is marke traumatic	2	William F. Mc 19a. Informant's Name/Relations		100	N. A4-11: A 44 (Ct.			elia Ry		
Ma	d a a a a a a a a a a a a a a a a a a a		W.J. McWilliams			b. Mailing Address (Str					
e,	E S E S		20e. Method of Disposition		20b. Place	146 Charles of Disposition (Name of ery, cremetory or other)		Date	20c. Location -		
mo	age ent o		1 X unal 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (St	3 Removel from State	9						
Baltimore,	교 된 원 중 .		21. Signature of Europeat Service t		St. M	ary's Cemet	cery 3/10/9	18 A	nnapoli	s, Ma	ryland
ä	Depa Impo any I		1/4/	0//2	10	1/7 5 1	dress of Facility John	M. Tay	lor Fune	ral	Home, Inc.
			23a. Pert1. Enter the disease, or shock, or haert failure. List	complications that cause	d the death. Do	The Date	OI OIGGE	DE DE	· Allilabu	lis,	MD 21401 Approximate Interval Between
ı	Physician /Medical		Immediate Causa (Final	a. Cae	Λ	a Del				/	Onset and Death
	Examiner		disease or condition resulting in daath)	a. Cale		consaguance of):	ydrat	(00)	() W	9,	wks wks
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68760,	ficata phys is tha	edicai	that initiated events rasulting in death) Last		Due to (or as a	consequance of):	K	MA	2/101		
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Вох	that the death cer led by the attendin detached for use	Physician/M	Don't Oliver of Many Accounts							- 1	
0	the d	hys	Part II. Ohter significant condition	ns contributing to darth I	out not resulting	In the underlying ceuse	given in Part I.		V		the cause of death?
S, D	£ 90	by P	Precent	nip 10	retr	V20-		101	2 No	3 Prob	ably 4 ☐ Unknown
Vital Records	been signe should be	Completed b	Deme	utia				24a. Was o	en eutopsy med?	ava	re autopsy findings ilable prior to appletion of cause
Re	S S S	du	Dlung	1-10-1	10	1 1	and			of d	eath?
ā		e C	25. Was cese referred to medicel	tiblled	dia	lets he)- 10 Y	1	1 🗆	Yas 2□ No
	sicle certi	To B	examiner?	Hospital:	ont o∏ ED/O		26. Placa of Death Other:	10			
0	ar this eral di	on: T	27. Manner of Death	28a. Date of Inju	ury 28b.	utpatient 3 DOA Time of Injury 28c. In	4 Li Nursing Ho		ence 6 LIOthe owninjury occurre)
Division of	Attending Physician: ar death. ector: After this certific by the luneral director,	atio	1 □Natural 5 □ Panding 2 ■ Accident Investig		98		Yes 2 No	400 6	Lan SO H	17.0	ant allow
N N	aftar death Director: A I in by the i	Certificati	3 Suicide 6 Could no daternois	ned 289. Place of in	jury - At homa, f c. (Specify)	arm, street, factory, offic	Se	2 1. Location (S	treet and Vumbern, State)	r or Rural	Route Number,
	tra aff	Ce		, and the same of	0	I hours	ノ	bifia	uklin	Thoop	Annabili
	Hosp 4 hou Fune taly fi	edical	2 Medical E	Physician: To the bast xaminer: On the basis of	of my knowledg	e, death occurred at the	tima, data and place, a	and due to the c	ausa(s) and mar	nner as sta	afed.
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the luneral	Med	29b. Signature and title of certifies	end manner st	eted.						
	F. 2 E 8	-	XOVO	111.1	0.0	↑ 29C. LICE	nse number	2	29d. Date signed	(Month, L	ay, Year)
		-	- Jeney	(VU		W () 1	1010		Mar	-ch	4,98
			30. Name and address of parson w Peter F. Verkou			(Type Print) Cal Parkway	Annapolis	. MD 21	401 (410	0-573	-1110)
	Stat	e	31. Date filed (Month, Dey, Year)	32. Registr	ar's Signatura			,			
			M/AD 111	CILIU CANTO	Figure 4	Dan 1.00					

1.5 CAT LET THE REPORT OF THE REPORT OF THE PARTY.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month Yaar BENJAMIN FRANCIS MARGE MARCH 20 1998 11:20 /Medical 4e. Facility Nama (If not institution, giva straat and numbar) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** VILLA ROSA HOME MITCHELLVILLE PRINCE GEORGE'S Hours Min. 8. Data of Birth (Month, Day, OCT 15, 5. Social Sacurity Number If Undar 1 Yaar 9. Birthplaca (Stata or Foraign Country) New York 7. Aga (In yrs. last birthday) **Funeral** Days 1 □ M 2 ⋤ F 084-10-7376 89 Yrs Director Usual Rasidanca of Dacadani the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at 1 ☐ Yas 2X No Directo Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Items 23a 3800 Lottsford Vista Road death Funeral 20721 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1X Yas 2 □ No 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status should be filed within 72 hours after and Mental Hygiene.
marked other than "natural", or Ites Navar Married 2 Married Baltimore, Maryland 21215-0020 If Yas, Giva Yaar or Datas: WW 11 1 ☐ Yas 2 No Specify: White þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Manager Insurance nt: If Nem 27 is marked and yor other 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumema) Be Peges 1 and 2 should be Charles Marge Mary Giaacone Marge 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Schaper 16002 Philmont Lane Mitchellville, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State permit. Pege Department or Important: If any Injury or once. Joyce Brothers F.H. 3 - 22 - 984 ☐ Dopation 5 ☐ Othar (Spacify) Malverne, NY 11565 e of Fyreral Sarvica Licensaa 21. Signatu 22. Nama and Addrass of Facility M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 bem Entar tha disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death Physician theno Sclenosis /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laeding to immadiata ceusa. Entar Undarfying Ceuse (Disaase or Injury that initiated events rasulting In death) Last Dua to (or as a consequence of): end Box 68760. Physician/Medicai Due to (or es e consequance of): esn P.O. Part II. Other significant conditions contributing to death but not rasulting in the undarlying ceusa givan in Part f. 23b. Did tobacco use contributa to the cause of death? signed by the 26 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performad? page 2 has certificate 1 ☐ Yas 2 ☐ No Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificantly filled in by the funeral director; 25. Was cese referred to medicel axaminar? Be 26. Placa of Death (Check only ona) Othar: Certification: To 1 Yas 4 Nursing Homa 5 ☐ Rasidance 8 ☐ Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Meryrer of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. fnjury at Work? 1 Natural 5 Panding 1 Yas 2 No 2□ Accidant invastigation 3 Suicide 6 Could not be 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 4 Homicida within 24 hours e To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and dua to the cause(s) and menner as steled.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and dua to the ceusa(s) and manner stated. edical 29a, Certifian To the 29b. Signature and itla of cartifiar 29c. Licansa numbar 29d. Date signed (Month, Day, Year)

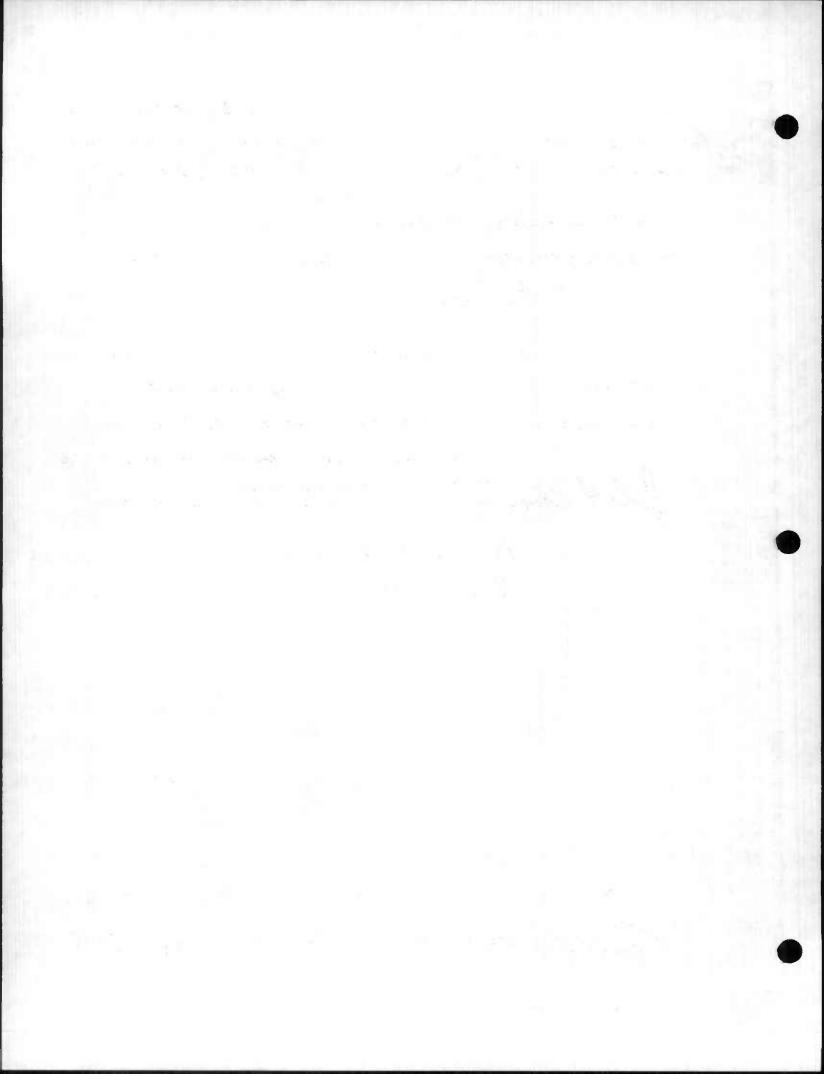
State Registrar 31. Data filed (Month, Day, Year)
MAR 2 3 1998. 32. Registrar's Fignatura

MAR 2 3 1998.

Rakesh Arora M.D., 14300 GAllant Fox Lane #222 Bowie, Maryland 20715

30. Nema and addrass of person who complated ceuse of death (Item 23a) (Type, Print)

Q



BALTIMORE, MARYLAND 21215-0020

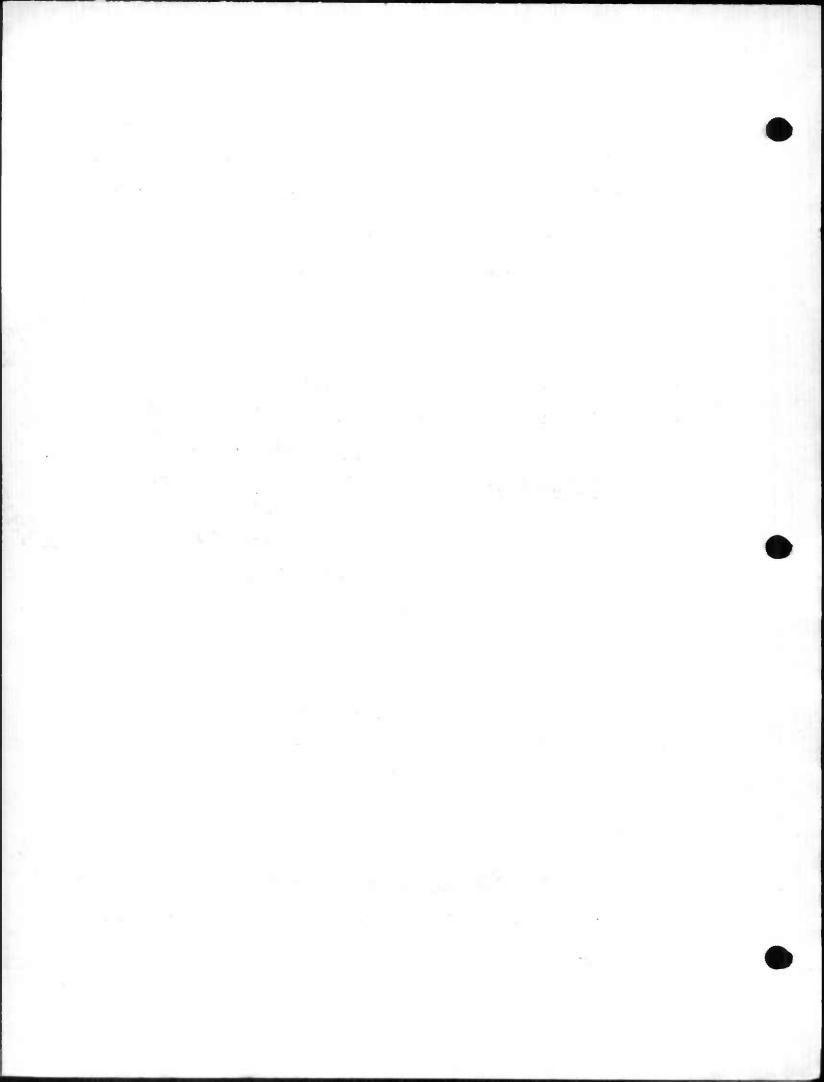
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunda-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bund, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

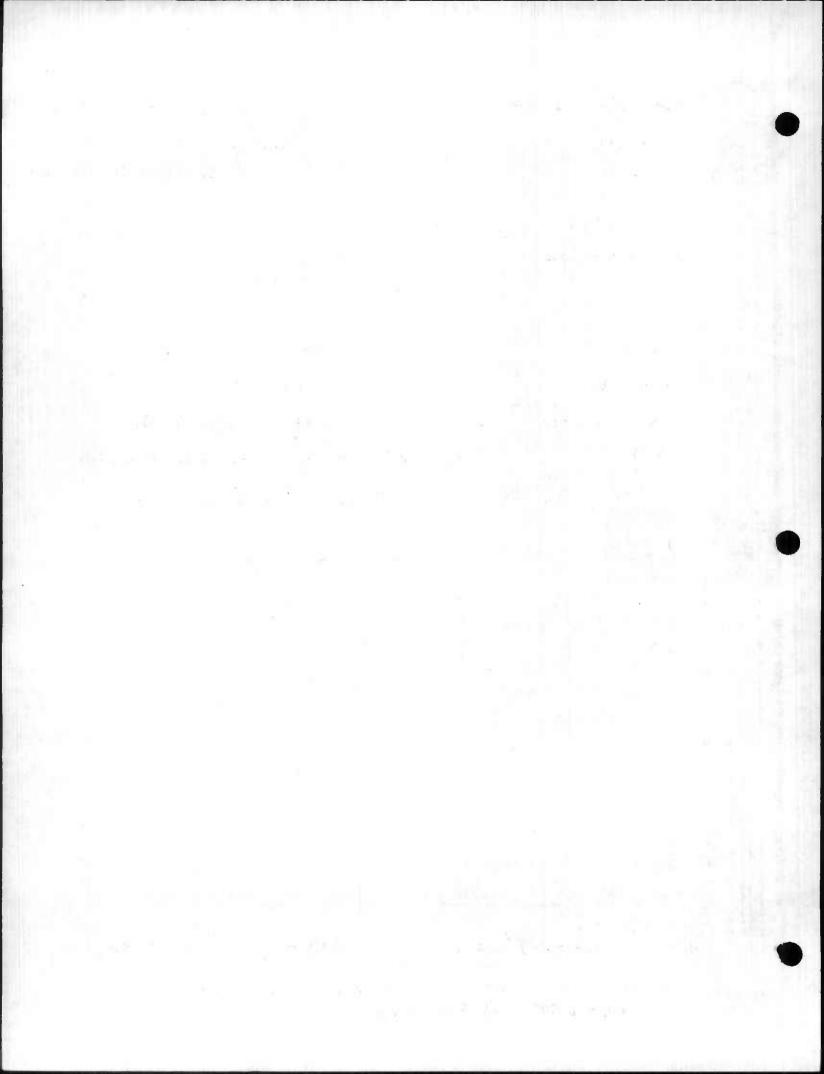
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTAL HYGIEN	E	0 10131
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	CHARLES MACK					MARCH 1	7, 19	998 4:25 PM M
		5. SEX 6. AGE (In	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign
	227-20-0537	1 X M 2 □ F 75	YRS.	MONTHS DAYS	HOURS MIN.	SEPT Day 1ar)	1922 V	VIRGINIA
	9a. FACILITY NAME (If not institution, give street	of and number)		9b. CITY, TOWN	OR LOCATION OF OR		9c. COUNTY	
OR	4585 LIVINGSTON ROA	AD		PO	MONKEY		CI	HARLES
<u>5</u>	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
DIRECTO	MARYLAND CHAR	I FC	-	OMONKEY				LIMITS?
- 1	100. STREET AND NUMBER	<u> </u>		Ι.	of. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?
FUNERAL	4585 LIVINGSTON ROA	AD/P.O. BOX	BRYA		20616		IINTTE	ED STATES
		12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	HC ORIGIN? (Specify Yes		I. RACE — American Indian.
	1 🔀 Never Married 2 🗌 Married	FORCES? TX YES		If yea, s	pecify Cuban, Maxica S 2 1 NO Specifi	n, Puarto Rican, atc.)		Black, White, atc. Specify:
D BY	3 Widowed 4 Divorced							BLACK
Щ	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION Impleted)	16a. DECEDENT'S	work done during n	ION lost of working	166. KIND OF BUS		Y BOARD OF
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +) YEARS	RETIRED		R	EDUCATIO		
M	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden	Sumamal	
	AARON MACK					HNSON MACK		
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	n, State, Zip Cr	ode)
2	VERA OWENS / SISTE	R	1348 2	9th ST.	NEWPORT	NEWS, VA	23607	7
	20a. METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Ramovi	20b.	PLACE AND DATE	OF DISPOSITION (leme of			y or Town, Stata
	4 Donation 5 Other (Specify)	GR	EENLAWN	MEM. CH	METERY	3/24 NEW	PORT N	EWS, VIRGINIA
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE John		THOR	NO ADDRESS OF FA	RAL HOME,	P.A.	
	AMBIA C. THORN	TON JOHNSON	410					HEAD, MD 20640
	23. PART i. Enter the diseases, or con shock, or heert failure. Lis	mplications that caused	the deeth. Do r	The second second				it, Approximate
	IMMEDIATE CAUSE (Final			Aus II.	- / A	1-0-1	11.	Interval Between Onset and Death
	disease or condition resulting in death)	CA	ndiac	anyin	/ A	hul Fibr	.(,)	New
		DUE TO (OR AS A	CONSEQUENCE O	F):	l L	1		man 1-
N O	Sequentially list conditions, b.	DUE TO (OR AS A			X	-	_	//
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	4	sent-					my yes
	CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A	1	F):				
H	resulting in death) LAST							
CE	PART ii. Other significant conditions	contributing to death by	it not requiting	in the underlyi	no cettee given in	Part I. 24s. WAS AN	AUTORRY	24b. WERE AUTOPSY FINDINGS
N S	The state of the s	ooming to down be	at not resunting	iii tile olideliyi	ng coose given in	PERFOR	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	-					1 TES 2	MO NO	OF DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	F DEATH Y	S D NO I	T LINCERTAI	<u> </u>		1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEA					
SIC		HOSPITAL:	atlant 3 DOA	OTHER:	me 5 Raaldence	6 ☐ Other (Specify)		
¥	27, MANNER OF DEATH	26a. OATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, II	JURY AT	26d. DESCRIBE HOW	INJURY OCCU	RED
BY	1 Natural 5 Pending 2 Accident Investigation	(MONRY, Day, Ibar)	1195		YES 2 NO			
	3 Suicida 6 Could not be	26a. PLACE OF INJURY building, atc. (Speci	— At home, farm,	street, factory, off	lea	261. LOCATION (Street City or Town, State)		Rural Route Number,
ETED	4 Homicide determined							
COMPLE		AN: To the best of my knowle	edga, death occurr	ed at the time, de	ta and placa, and dua	to the cause(a) and ma	nner as stated	i.
Š Ö	one) 2 MEDICAL EXAMINER:	On the besis of exemination	and/or investigation	on, in my opinion,	death occured at the	time, data and placa, ar	id due to the	cause(a) and manner as stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	/ \	17		29c. LICENSE NU		29d. DATE S	SIGNED (Month, Day, Year)
0	15	· Day		wo.	258	540	3	315/98
	30. NAME AND ADDRESS OF PERSON WHO							
	KHOSROW DAVACHI. 1 31. DATE FILED (Month, Dey, Year)	M.D. 1328 SC 32. REGISTRAD'S SIGNA		AVE. S.	E. SUITE	202 WASHIN	GTON,	D.C. 20032
	MAR 2 3 1998	Jalin Dhude	orRevall					



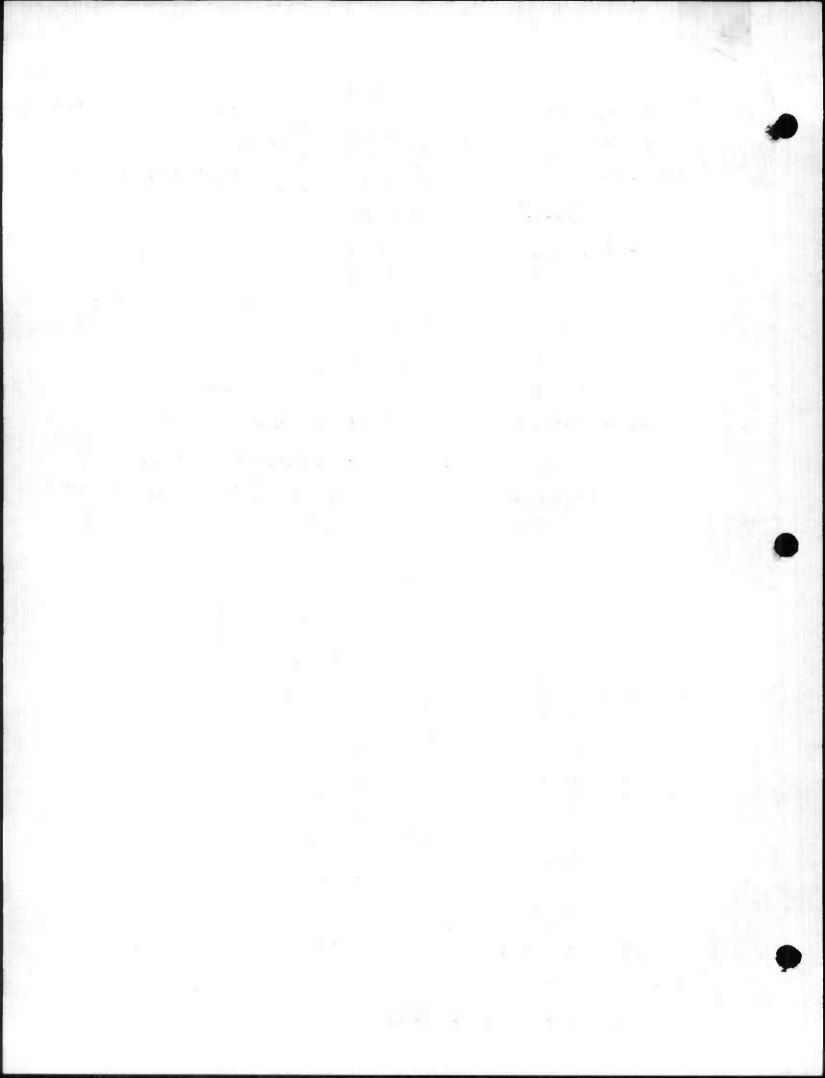
State of Maryland / Department of Health and Mental Hygiene

Securitary Sec	eorge's Inthplace (State or Foreign ountry) 10d. Inside City Limit: 1 Yes 2000 ountry? erican Indian, ite, etc. White
Fig. 2 Section Security Number 6. Sex 578 - 0.7 - 4.714 1 10 20 F 8.7 vs. Months 1 2 Section Security Number 578 - 0.7 - 4.714 1 10 M 20 F 8.7 vs. Months 1 2 Section Security Number 578 - 0.7 - 4.714 1 10 M 20 F 8.7 vs. Months 1 2 Section Security Number 578 - 0.7 - 4.714 1 10 M 20 F 8.7 vs. Months 1 2 Section Security Number 578 - 0.7 - 4.714 1 10 M 20 F 8.7 vs. Months 1 2 Section Security Number 578 - 0.7 - 4.714 1 10 M 20 F 8.7 vs. Months 1 2 Section Security Number 578 - 0.7 - 4.714 1 10 M 20 F 8.8 months 1 2 Section Section Marbury 1 10. City Code 2 20.658 1 10 Mary 1 and 1 10 Mary 1 and 1 10 Mary 1 and 1 10 Marbury 1 10. Express and Number 4 800 Bicknell Road, P. O. Box 417 2 20.658 1 USA 1 11 Martial Status 1 10 Normal Marbury 1 10 Mary 1 10 Marbury 1 10	eorge's Inthplace (State or Foreign ountry) 10d. Inside City Limit: 1 Yes 2000 ountry? erican Indian, ite, etc. White
Use a least consequence of the contributing in death but not resulting in the underlying cause given in Part I.	10d. Inside City Limit: 1 □ Yes ②CXNo country? erican Indian, ite, etc. White
Elementary/Secondary (0-12) 12 12 13 15 16 16 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	1 □ Yes 2,CNNo country? erican Indian, ite, etc. White
Elementery/Secondary (0-12) 12 12 13 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18	erican Indian, ite, etc. White
Elementery/Secondary (0-12) 12 12 13 15 16 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	ite, etc. White s/Industry
Elementery/Secondary (0-12) 12 13 15 16 17 18 18 18 18 19 19 19 19 19 19	
17. Fether's Neme (First, Middle, Last) Sylvester Corn 19a. Intormant's Neme/Relationship (Type, Print) Arthur L. McMurray — Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Arthur L. McMurray — Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Arthur L. McMurray — Son 19c. Method of Disposition 10c. Migrain a 2 gradient of State of Disposition (Neme of Commerce) 19c. Method of Disposition 10c. Migrain a 2 gradient of State of Disposition (Neme of Commerce) 19c. Method of Disposition 10c. Migrain a 2 gradient of State of Disposition (Neme of Commerce) 19c. Mark G. Brohawn 19c. Neme (First, Middle, Maiden Surname) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Arthur L. McMurray — Son 2291 Westwood Drive, Waldorf, MD 20601 10c. Migrain a 2 gradient of State of Disposition (Neme of Commerce) 19c. Mark G. Brohawn 19c. Neme (First, Middle, Maiden Surname) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Arthur L. McMurray — Son 2291 Westwood Drive, Waldorf, MD 20601 10c. Migrain a 2 gradient of State of Disposition (Neme of Commerce) 19c. Mark G. Brohawn 19c. Neme of Address of Feelity Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604—0156 23a. Pertl. Einter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, 19c. Migrain a 2 gradient of State of Migrain and State of Sta	
Sequentially list conditions	
Comparison Comment C	Zin Code)
Comparison Comment C	Lip obdey
Physician /Medical Examiner Physician /Medical Examiner Sequentially list conditions, if only, leading to immediate cause. Enter Underlying 20 cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of):	
Physician /Medical Examiner Physician /Medical Examiner Sequentially list conditions, if end, leading to immediate cause. Enter Underlying cause in liquid that initiated events resulting in death) Lest Due to (or as a consequence of):	6
Part iii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute 1 Yes 2 10 No 3 P	
To the symmetric continuous conti	
	robably 4 Unknow
Pro Non Q ware mystaded uplates 240. Wes an autopsy performed? 1 Yes 2 10 No	Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 25. Was cese reterred to medicel examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Description of the control of the contr	1 ☐ Yes 2 ☐ No
25. Was cese reterred to medicel examiner? 1 Yes 2 No 25. Was cese reterred to medicel examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Deeth 28. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 3 Suicide 6 Could not be determined determined determined determined and the suitable of	icify)
24e. Wes an autopsy performed? 24b. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24c. Wes an autopsy performed? 1 Yes 2 No 24d. Wes an autopsy performed? 1 Yes 2 No 25. Was cese reterred to medicel examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Deeth 1 Whatural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Date of Injury - At home, tarm, street, tactory, office 28e. Place of Injury - At home, tarm, street,	ural Route Number,
29a. Certifier 29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner est	s stated. s to the ceuse(s)
	th Day Year)
7 Jm 2 / Duke M D01009 3-17-99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Henry L. Burke, 115-A LaGrange Avenue, La Plata, MD 20646 State Registrar MAR 2 0 1998	



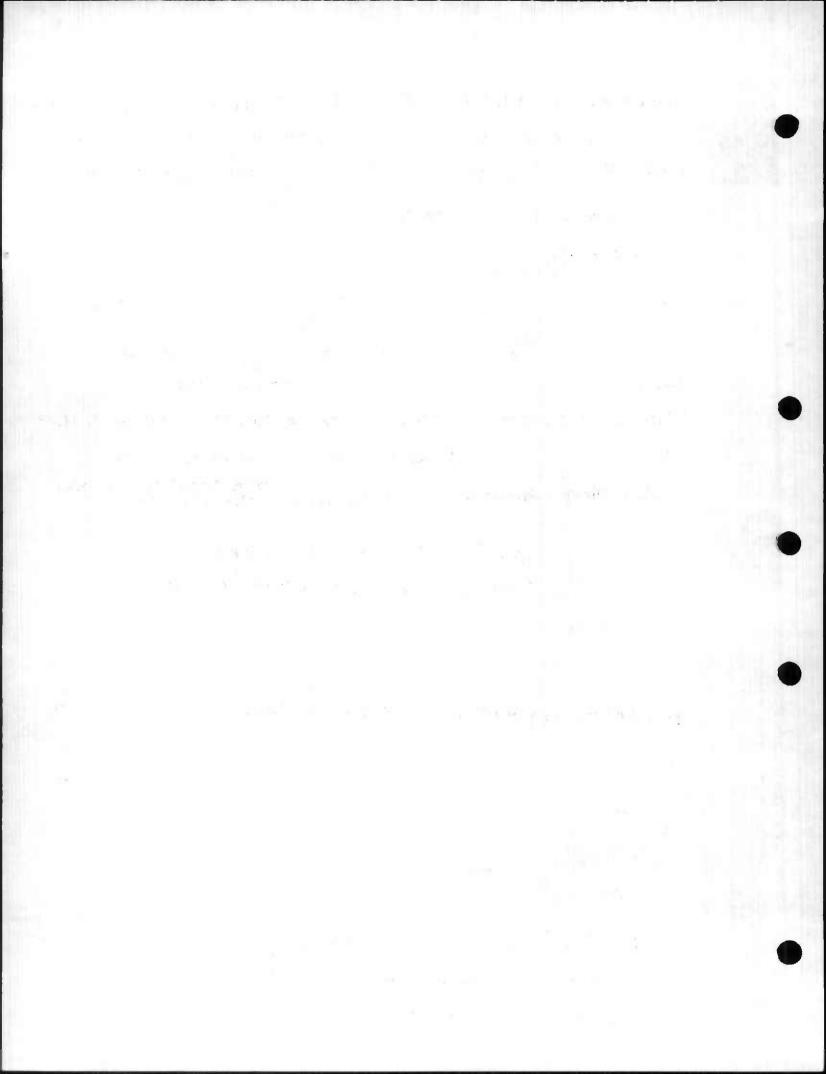
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	aryland /	Certificate of		, ,	iene g. No.	1	0133
	Dhuaisi		1. Dacedent'a Neme (First, Middla, La	st)				2. Defa of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Edward C. Minor					Mar.	16 1998	3	11:50 am
8	Examir		4e. Fecility Neme (If not institution, give	e street end number)			4b. City, Town, or L		4c. County		
4			Fairhaven Healt				Sykesvil		Carr	coll	
	Funeral Director		5. Social Sacurity Number 6. S 217-09-0626 Usual Residance of Decedent	3 7. Ag	a (in yrs. iast b	Yrs. If Under 1 Year Months Deys		8. Dete of Birth (Month, Dey, Mar. 29	1904	Cour	plece (Stete or Foreign http: Yland
	and and		10a. Stata 10b. County		10c. City, To	wn or Location				1	0d. Inside City Limits
	Mary	tor	MD Carr	oll	S	ykesville					1 ☐ Yas 2 ☐ No
	h with the	ai Director	10a. Streef and Number 7200 Third	Ave. C-74	1	10f. Zip Code 21 78	34	10	Og. Citizen of W		ntry?
Maryland 21215-0020	be filed within 72 hours after death with the Maryland tial Hygiene. diother than "natural", or itema 23a or 28a-1 show event, the Medical Examination notified at	by Funeral	11. Marifal Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forces? 1 Yes 2 16 If Yas, Giva Yaar or Detes:		13. Was Decedent of If Yas, apecify Cut	oan, Maxican, Puarto	pecify Yas or No- p Rican, atc.)		k, White,	
5-0	72 h	Completed	15. Decedant's E	ducation ade completed)	16	a. Decedent's Usuel Occu (Giva kind of work dona life. DO NOT usa ratire	pation during most of work	king	16b. Kind of Bu	siness/in	dustry
121	within ene.	mpi	Elementery/Secondery (0-12)	College (1-4or 5	i+)		9d)		Archit	-ooti	iro
d 2	filed v Hygie fther t		17. Fathar's Nama (First, Middla, Last	4		Designer	18. Mother's Nem	ne (First, Middle, M			ire
an	2 should be filed with! and Mental Hygiene. is marked other than surratic event, the M	o Be	Benjamin W.				100 100 100 100 100 100 100 100 100 100	he Carr		-/	
ary	should Mark	To	19e. Informent's Neme/Reletionship (19	9b. Meiling Address (Stree			City or Town,	Steta, Zip	Code)
ž			Roberta M. Minor	(wife)		7200 Third	Ave. Syke	sville M	ID 21784	4	
Baitimore,	Pages 1 and nent of Health int: if Item 27 iry or other tr		20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specif		cemat	of Disposition (Neme of lary, crametory or other pla oll Crematic			20c. Location -		
Bait	permit. Pages 1 Department of F important: If ite eny injury or ot		21. Signeture of Funerei Service Licer		d	22. Nama and Addr	ess of Facility Ha	aight Fur esville M			Chapel
			23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plicetions thet caused	the deeth. Do						Approximete Interval Between
1	Physician		Juneracco com una								Onaet end Death
Ø	/Medicai Examiner		Immediate Ceuse (Final disease or condition	relaps	ing p	pneumonic					Zmenths
li i		disease or condition resulting in deeth) Due to (or es e consequence of):									
Т	nsit	min		b		is demen	hia				5 years
ć	icate be executed physician and s the burial-transit	edical Examiner	Sequantially list conditions, if any, leeding to Immadiate cause. Enter Underlying		Due to (or es	e consequence of):				į	
68760,	te be ysicia		that initiated avants	C	Dua to (or as a	consequence of):					
Box 68	death certifica e attending ph od for use as th	Physician/Med	resulting in death) Last	d						i I I	
ω.	death	sicia	Pert II. Other significant conditions of	iven in Part f.	23b. Did to	ntribute to	the cause of death?				
P.O.	that the de ed by the a detached i	Phy						1 □ Ye	s 2MNo	3 Pro	bably 4 Unknown
	2 5 2	þ									
of Vital Records,	e law requires has been sign je 2 shouid be	Completed						24a. Wes en	n eutopsy ned?	av co	ere autopay findings sliable prior to mpletion of cause death?
E	The ate h							1□ Y€	s 2000	1[Yes 20XNo
Vita	ysician: The s certificate director, pag	Be	25. Wes case referred to medical examiner?	Manhal				th (Check only on	e)		
of	this aid	70	1 Yas 2 No			Julpatient 3L DOA		ome 5 Reside			y)
Division	Attending F er death. ector: After by the funer	Certification:	27. Menner of Deeth 1 Netural 5 Pending 2 Accident Invastigefior 3 Suicide 6 Could not b		Year)		Yea 2□No	28d. Describe ho			
DIX	ital or Atl irs after d ral Direct lled in by	Certifi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide datarmined	28e. Plece of Injubuilding, etc	ury - At home, c. (Specify)	ferm, atreet, fectory, office		28f. Location (St City or Town		er or Run	al Routa Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledicai	(Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of end menner ste	examinetion e	ge, deeth occurred et the t and/or Investigation, in my	opinion, deeth occur	rred at the time, de	ete and plece, a	and due to	the cause(s)
	To Toop	Σ	29b. Signeture end title of certifier	mi	MO		sa number	2	9d. Data signed		Day, Year)
			30. Neme and address of person who					-1			
						iberty Rd.	Elden	riburg,	MP	217	84
	Sta Registr		31. Dete filed (Month, Dey, Year)	- 1.41 0	era Signature	2.11					
211	ricgisti	ai	MAR 1 8 19	38 Just 10	WANTED TO	STORALL.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certi	ificate of	Death		Reg. No.	10134
Physici /Medic		1. Decadant's Nama (First, Middle MARGARE	o, Lost VER	NE	MC	CUL	LEN	2. Date of D	Day	Year 1157 A
Examin		4a. Facility Nama (If not institution NORTHWEST	n, give street end number) HOSPITAL	CEN	VTE	1	4b. City, Town, or	Location of Dea		of Death LTIMORE
Funerai Director		5. Social Sacurity Numbar 226-42-3482	6. Sex 7. Ag	ga (In yrs. lest bir 9		If Under 1 Year Months Days	If Undar 24 Hr. Hours Mir		rth ey, Yeer) 1918	Birthplaca (Stata or Fore Country) New Jersey
r 28a-f show	tor	Usual Rasidence of Dacedant 10a. Stata 10b. County Md. Carrol		10c. City, Tow				-		10d. Insida City Llmi
th with the 23a or 28a	Funeral Director	10e. Street and Numbar 7200 Third Aver	nue			10f. Zip Coda 21784			10g. Citizan of V USA	Vhat Country?
aftar daa or items	by Funer	11. Marital Status 1 ☐ Navar Marriad 2 ☐ Marr 3 ☑ Widowad 4 ☐ Divorced	12. Was Decedant Armed Forcas? led 1 Yas 2 If Yas, Giva Yaar or Datas:		IT Y	s Dacedant of Has, specify Cub	Hispanlc Origin? (: an, Maxican, Pue Specify:	Specify Yas or N rto Rican, atc.)	Blac	a - Amarican Indian, ck, Whita, atc. White
within iena. than "	Be Completed by	15. Decedan (Specify only higher Elementary/Secondary (0-12)	l's Education st grede completed) College (1-4or s		(Give kin life, DO	nt's Usual Occup nd of work dona NOT use retire	during most of wo d)	prking		usinass/Industry
uld be filed lental Hygid ked other lic event, III	To Be C	17. Fathar's Nama (First, Middle, Howard G. Law	•			-		ma (First, Middle Verne Bi	, Maiden Sumem	
nd 2 should alth and Men 27 is marke r treumatic		19a. Informant's Nama/Ralations William R. McCul							per, City or Town, Hinesvi	Stete, Zip Code)
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other treumatic event, once.		20a. Mathod of Disposition 1 Burial 2 Cramation 4 Donation 5 Othar (S)		20b. Placa of cemeter	f Dispositi ry, cremet	ion (Nema of tory or other pla Cemeter	ce)	Data		City or Town, State
pemit. Departnimporta any inju		21. Signatura of Funaral Sarvica Paige Haig		7		lama and Addra	ss of Facility Ha	ight Fur		me & Chapel
	n/Medical Examiner	Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last	a. RES b. CONG c.	Due to for as a r	conseque VE consequa	nce of): CA nce of):				
es that tha igned by th be detache	ted by Physician/	Part II. Other significant condition MYELO PRO	_					D; 1□	Yes 2 No	arribute to the cause of dea 3 Probably Probably 24b. Wara autopsy finding available prior to
has b	Completed			_					Yas 2 No	completion of causa of death?
iling Physician: Aftar this certific	To Be	25. Was case raferred to medical axaminar? 1 Yas 2 Too 27. Mannar of Death 1 Natural 5 Pandin invastic	ation	ry 28b. 1	Itpatient Time of njury	3 DOA Oth 28c. Injur Wor M 1	ear: 4 Nursing	1	one) idanca 6 □Othi how injury occurr	
To the Hospital or Attand within 24 hours aftar deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicida 6 Could r 4 Homicide daterm	building, etc					City or To	wn, State)	er or Rural Route Number,
To the Hospital within 24 hours. To the Funeral completely filled	Medical	(Check only 2 Madical I	g Physician: To tha best of Examiner: On the besis of and mannar sta	f axamination and	, daath oo d/or invas	tigation, In my o	pinion, death occ	e, and dua to the urred at the time,	date and place, i	and dua to tha causa(s)
Vitt To	Σ	29b. Signatura and titla of certifiar	in les			D 3	733 ₃			d (Month, Dey, Year) 1 12,1998
		30. Nama and address of person	who completed causa of d	leath (Item 23a) ((Type, Pri	LTD. M	0211	3.7		
Stat Registra		31. Data filed (Month, Day, Yeer)	32. Registra	ar's Signatura	Park II	,				



State of Maryland / Department of Health and Mental Hygiene Q Q

				,,,	Cert	ificate of	Death	Re	g. No.	5 10	135
	Physici /Medic		1. Decedent's Neme (First, Middle, Last) CAM 1 LL E		MAR	CELL	1110	2. Dete of Death Month		Yeer	Time of Death
à	Examir		4e. Facility Name (If not institution, give stre Washington Adventi	Control Control			4b. City, Town, or L Takoma	ocation of Deeth	4c. County	of Death	~~/,1/
	Funeral Director		5. Sociel Security Number 6. Sex 1	2 F 7. Age (In yrs. In 83		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Nov. 23,	Yeer)	gomery 9. Birthplece Country) Washing	(Stete or Foreign
	larylend show	J.	Usual Residence of Decedent 10a. Stete 10b. County		, Town or Loca						nside City Limits Yes 2 No
	d within 72 hours after death with the Marylend jiene. Tithan "natural", or Items 23a or 28s-f show the Med cal Examiner must be notified at	ral Director	Maryland Prince Geo 10e. Street and Number 5999 Emerson Stree	t	ladensb	10f. Zip Code 2071(~		g. Citizen of W	١.	
020	ours after de rai', or item Examiner n	by Funeral	1 ☑ Never Merried 2 ☐ Married	Wes Decedent Ever in U,\$ Armed Forces? 1 ∐ Yes 2 ሺ No If Yes, Give Yeer or Detes:		es Decedent of F res, specify Cub ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Ind. k, White, etc. White	dien,
21215-0020	within ane. than	Completed	15. Decedent's Educati (Specify only highest grade of Elementery/Secondery (0-12)	on mpleted) College (1-4or 5+)	(Give kii	nt's Usuei Occup nd of work done O NOT use retire	during most of world	king	6b. Kind ol Bu	siness/Industry	,
land 2	d be filed ental Hygid ced other cevent, II	Be	17. Fether's Name (First, Middle, Last) Vincent Marcellino	-	Dayer			e (First, Middle, M	laiden Sumem		
Maryland	ind 2 should be filed eith end Mental Hyg 27 is merked other ir traumetic event,	Ţ.	19e. Informent'e Name/Reletionship (Type, Anthony Navarro - N				end Number or Ru	ral Route Number,	City or Town,		
Baltimore,	oth eth		20a. Method of Disposition 1 🖾 Buriai 2 □ Cremation 3 □ Remark 4 □ Donetion 5 □ Other (Specify)	20b. Pi	ece of Disposit metery, creme	tion (Name of ottory or other place) oln Ceme	/	Dete 2	Oc. Location -	20736 City or Town, S	Stete
Ball	permit. Peges Department of Important: If It any injury or once.		21. Signature of Funeral Service (icensee	0	Fr: 47	39 Balti	asch's Son	que. Hvat	tsvill	, P.A.	20781
	Physician /Medical		23a. Pert1. Enter the disease, or comblicetishock, or heert feiture. List only one commendate the combined of	ons thet caused the death euse on each line.	. Do not enter	the mode of dyi	ng, such as cardiec	or respiretory erre	st,	Appl	roximete vei Between et end Death
	Examiner	Examiner	resulting in deeth) e	Kespira	as a conseque	y Ja	·lure	,		10	lag
Box 68760,	2 0 0	edical	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	Pulmo	es a conseque es a conseque	200	dem	9.		110	day
P.O. B	es thet the death cer igned by the attendir be deteched for use	Physician/M	Pert II. Other significant conditions contrib	101		4	ven in Part I.	23b. Did tot	A . C		causa of death?
Records, F	law requires thet the es been signed by th 2 should be detech	þ	Dialeteo	d Stage	reu Jus:	al je	KILLY PE	24a. Was an	autopsy	24b. Were eu	utopsy findings
	The law rate hes by page 2 sh	Completed		roceri				1 □ Ye	s 2 No	of deeth	-
of Vital	Attending Physician: ir death. sctor: After this certific by the funeral director,	Be	25. Wes case referred to medical exeminer?	sital:		Ott	26. Place of Dee	th (Check only one)		
o	Physical direction	2	TE TES ZIENO	Y⊠Inpatient 2∐E	28b. Time of	3LI DOM	4 LI Nursing A	ome 5 Resider			
0	th. After	tion	1 Accident 5 Pending investigation	(Month, Dey Year)	Injury	28c. Inju Wo M 1	rk? Yes 2∐No	200. 5000,100 110	in injury cocurr	00	
Division		Certification:	3 Could not be	8e. Place of Injury - At hos building, etc. (Specify,	me, larm, stree	t, lactory, offica		28l. Location (Str. City or Town,		er or Rural Rou	te Number,
		edical	29a. Certifier (Check only one) 15 Certifying Physicia 2 Medicai Examiner:	n: To the best of my know On the basis of exemineti end menner steted.	vledge, deeth o on end/or inves	occurred et the til stigation, in my c	me, dete end pieca, optnion, deeth occur	red et the time, de	te end piace, e	end due to the o	cause(s)
	13 13	Σ	29b. Signature and fittle oil certifier			29c. Licens	09			Month pey.	1998
			30. Name and address of person who complete RAMAN R. TULL	T		NOUNT	RAINIE	R.MD	2071	2	
	Sta	te	31. Dete liled (Month, Dey, Year)	32. Registrer's Signet	ure						

MA 20 BB Johnston Land

State of Maryland / Department of Health and Mental Hygiene Q 8

				Ce	rtificate of	f Death		Reg. No.	0 1	1130
Phys	cian	1. Decedent's Name (First, Mid	_	264			2. Date of Dec	eth	Voor	. Time of Death
	dicai	ALLINE	E	MATHU	RIN		Mar 11	_		12:52am
Exan	niner	4a. Facility Name (If not institut HOLY CR	OSS HOSPITAL			4b. City, Town, or L SILVER SP	RING	MONTG		
Funer Directo	_	5. Social Security Number 578–26–1807 Usual Residence of Decedent		yrs. lest birthday) 5 Yrs.	If Undar 1 Year Months Day		8. Date of Birt	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		(State or Foreign
Maryland H show	tor	10a. State 10b. Coun	NTGOMERY 100	City, Town or Lo						Inaide City Limits
ith with the 23a or 28	Funeral Director	10e. Street and Number 4506 FALCON C	OURT		10f. Zip Code 2085:			10g. Citizen of V	What Country?	
and ZIZIS-UUZU be filed within 72 hours efter death with the Manyland the Hydione. d other than "netural", or ferme 23e or 28e-f show event, the Medical Examples must be not to all	by	11. Marital Status 1 Never Married 2 Maried 3 Widowed 4 Divorce	If Yes, Give		Was Decedant of f Yes, specify Cu 1 ☐ Yes 2 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto O Specify:	pecify Yas or No- Rican, etc.)		ce - American li ck, White, etc. y: BLAC	
within 72 h within 72 h ene. than "natur	Completed	15. Decade (Specify only high Elementery/Secondery (0-12 12 YEARS	ent's Education pest grade completed) College (1-4or 5+) NONE	(Give	dent's Usuel Occ kind of work don DO NOT use retii	e during most of work red)		16b. Kind of B	usiness/industr	
	To Be Co	17. Father's Name (First, Middle ALBERT CARTER	e, Last)	VIINDI	NG HODI	18. Mother's Nam	e (First, Middle,		ne)	
2 short and halls main		19a. Informent's Neme/Relation	nship (Type, Print)	19b. Mailir	ng Address (Street	et end Number or Rui	rel Route Numbe	or, City or Town,	Stete, Zip Coo	de)
ages 1 end nt of Health if item 27	20		20 3 Removal from State	b. Plece of Dispo	sition (Neme of natory or other p		Date	20c. Location		State
Defilliofe, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic ex		4 Donation 5 Other 21. Signature of Funeral Service	opeony)		. Nama and Add	OHN Ficility RHI	NES CO.	, INC.	к, по.	
Physicia /Medica Examine	l I	23a. Party Enter the diseasa, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting In death)	or complications that caused the st only one cause on each line. a. Attento						Inte On:	proximate erval Between set and Death
eath certificate be executed ettending physician and for use as the burial-transit	an/Medicai Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	S h. AtriAL Due	to (or es a consequence de la consequence del consequence de la co	(11 tiun number of):					
that the death cert ed by the ettendin detached for use	Physician/	Part II. Other significant condi	tions contributing to death but not	t resulting In the u	nderlying cause (given in Part I.	1	obacco use co		cause of death?
ne law requires has been sign ge 2 should be	Completed by						24a. Was a perfor	med?	availeb comple of deat	autopsy findings la prior to stion of cause h?
ysician: The lav ysician: The lav ls certificete has director, page 2	BeC	25. Wes case referred to medic examiner?	eal			26. Place of Deer		-	10.0	5 2010
g Physician: er this certific	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	I SLI DON		ome 5 Resid			
Hospital or Attending Physician: The Hospital or Attending Physician: The Hours effect death. Runeral Director: After this certificate lety filled in by the funeral director, pe	Certification:	3 Sulcide 6 □ Coul	tigation	At home, farm, str	M 1[Yes 2□No	28f. Location (S City or Tow		per or Rural Ro	ute Number,
o the Hospital of the St. Abours of the Funeral Completely filled	edical Ce	29a. Certifier (Check only one)	ing Physician: To the best of my il Examiner: On the basis of exer and manner stated.	knowledge, deeth	occurred at the restigetion, in my	time, date and placa, opinion, deeth occur	and due to the o	cause(s) and mediate and place,	anner as stated and dua to the	I. cause(s)
1	Me	29b. Signature and title of cont	Culenn	NO	29c. Licer	nse number		29d. Date signe		Year)
0	1	30. Neme end address of person Hope Havener	n who completed cause of death MD 10810 Conn			MD 20895				

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

MAR 17 1998

med I I like you what we have

DAVID McCOY

State of Maryland / Department of Health and Mental Hygiene

cate of Death Reg. No.	,

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last) David J. McCoy

2. Date of Deeth MARCH

3. Time of Deeth

4b. City, Town, or Location of Death

11, 1998 8:38P.M. 4c. County of Death

PRINCE GEORGES

Funeral Director

the Maryland r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examples must be a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

13. If form 27 is marked other than "natural", or florme 23 mit. If form 27 is marked other than "natural", or other traumatic event, in "tendical Exprise musary or other traumatic event, in "tendical Express musary". Baltimore, Maryland 21215-0020 permit. Page Department of important: If any injury or page.

> Physician /Medical Examiner

physician and the burief-transit 88 USB signed by the a page 2 has certificate funeral 24 hours after death. Funeral Director: At

Completed

Be

10

Certification:

edicai

that the death certificate be exec

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Directo Funerai P Completed Examiner Physician/Medical by

4a Facility Nama (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER 5 Social Security Number

10 M 20 F

S.E.

7. Age (In yrs. last birthday) Months Yrs. 24

10c. City. Town or Location

CHEVERLY If Under 1 Year Deys Hours Min

8. Date of Birth (Month, Day, Year) 3/16/73

 Birthplace (State or Foreign Country) Wash. D.C.

10d. Inside City Limits

1X Yes 2 □ No

Usual Residence of Decedent 10a State 10b. County

351-53rd.

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

D.C. 10e. Street end Number Washington

10f. Zip Code

20019

1 Yes 2 No Specify:

10g. Citizen of What Country? U.S.A.

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)

14. Race - American Indian, Black, White, etc. Specify: Black

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+)

St.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietary Worker

16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last)

4 ☐ Donation 5 ☐ Other (Specify)

18. Mothar's Name (First, Middle, Maiden Sumame)

Private

David McCoy 19a. Informant's Name/Relationship (Type, Print)

351 53rd St. S.E.Wash.D.C. 20019

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

Elaine McFadden

David McCoy Father 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other placa) Harmony Mem. Pk.

20c. Location - City or Town, State Date 3/18/98 Landover, Md.

21. Signature of Funeral Service Licansee

22. Name and Address of Fecility

Hodges and Edwards 3910 Silver Hill RD. Suitland, Md. 20746

award 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, cck, or heart failure. List only one cause on each line.

Dua to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disaase or injury that initiated events resulting in death) Last

Immediata Causa (Final disease or condition resulting in death)

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably ♣ Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of ceuse of death?

Approximate interval Between Onset end Death

1 Yes 2 □ No 26. Place of Death (Check only one)

1 Pores 2 No

25. Was case referred to medical axaminer? 1⊠ Yes 2□ No

27. Mannar of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicida

29a. Certifier

5 Panding invastigation

6 Could not be

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of fnjury _(Month, Day Year) 3-11-08

28b. Time of fnjury 1922 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Prier in multi while collism

28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Phyeicfen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Whether the phyeicfen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. - Comptony

29b. Signature and title of certif

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) MARCH 14, 1998

of person who completed gausa of death (itam 23a) (Type, Print) 30. Name and add

31. Date filed (Month, Day, Year, MAR 1 7

egistrar's Signature

Registrar

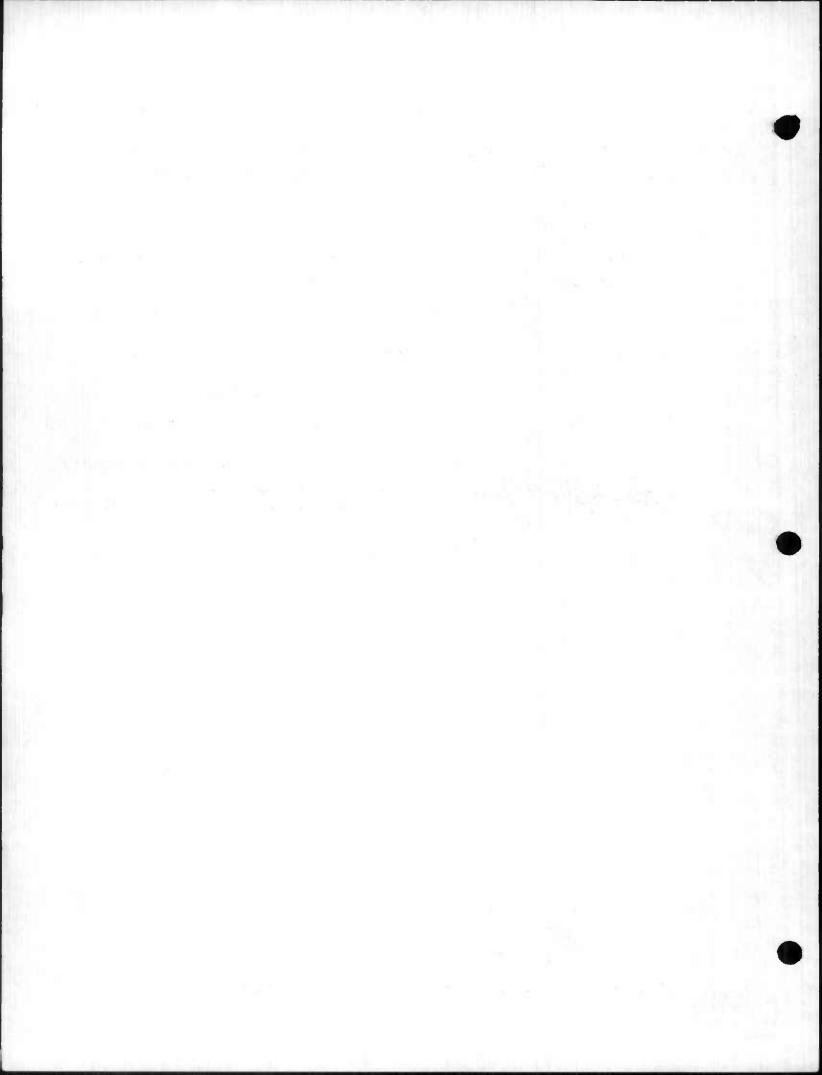
To the Hosp within 24 hor To the Fune completely fi

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State of Maryland / Department of Health and Mental Hygiene 9

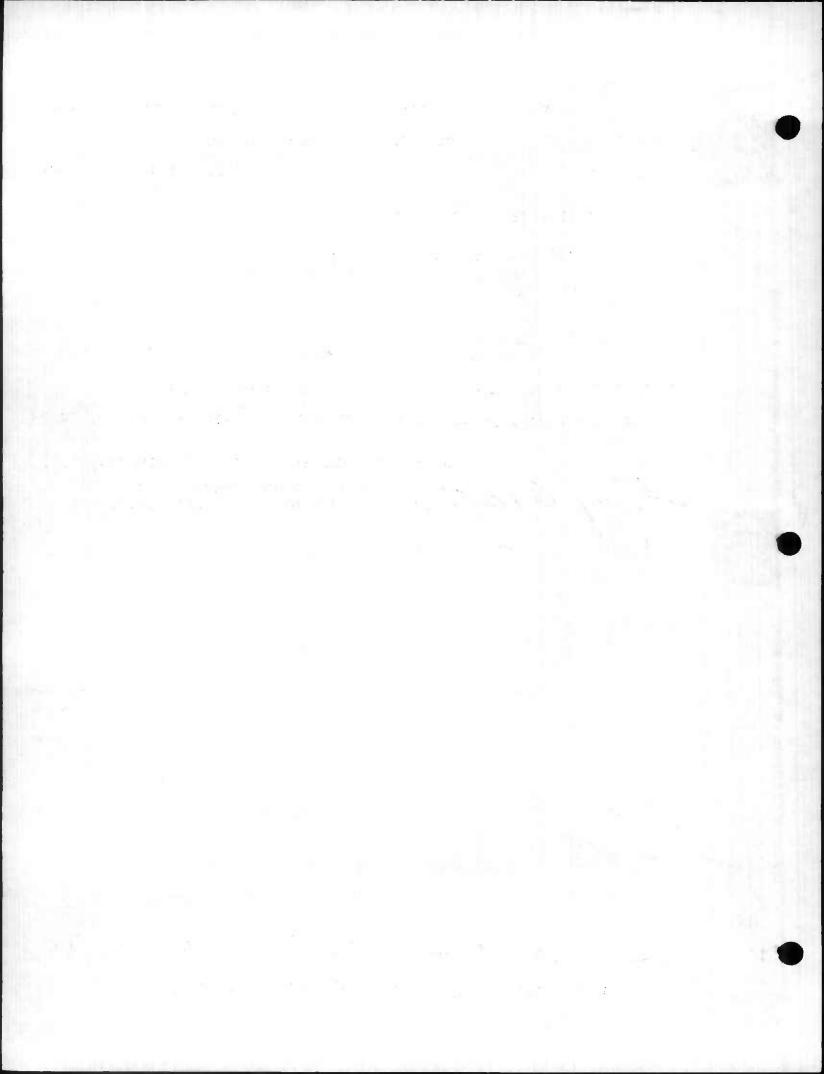
						Certifi	cate of	Death	R	eg. No.	0 1	0130
			1. Decedent's Name (First, Middle, La	st)					2. Dete of Dee Month	th _	Voor	3. Tima of Death
	Physici /Medi		Frank	M	cCarty	7			March	14, 1	9 98	10:50 A
	Exami		4a. Facility Neme (If not Institution, giv					4b. City, Town, or	Location of Death	4c. Count	ty of Death	
		, 1	The Memo	rial Hosp	ital			Eas	ton	Ta	lbot	
	Funeral Director		5. Sociel Security Number 6. S 216-18-2623	ex 7. Ager OXM 2□ F	(In yrs. last birti		Under 1 Year onths Days	If Under 24 Hrs Hours Min.		Yeer)		plece (Stete or Foreigntry) aryland
	anyland show	L	10a. Stete 10b. County		10c. City, Town	or Locatio	n					10d. Inside City Limit
	Ba-f	Director	Maryland Carolir	e	Harmo	-						1 ☐ Yes 2 💢 N
	ath with t	ral Dir	10e. Street end Number Unknown				of. Zip Code 2165			og. Citizen of Unite	d Sta	ites
21215-0020	72 hours after death with the Maryland natural; or items 23a or 28a-f show deal Examinal prut be notified at	by Funeral	11. Marital Status Unknown 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: T			Decedent of logs, specify Cub	Hispenic Origin? (S een, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Speci	ack, Whita,	
2-0	72 hours "natural", so cal Exe	ted	15. Decedent's Ed	lucation	16a.	Decedent's	Usuel Occu	petion	rking	16b. Kind of E		
21	C . W	Completed	(Specify only highest gre Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO N	IOT use retire	during most of wo	rking			
2	filed within Hygiena. ther than " ent, the Mes	Con	Unknown			arm I	Labore	_		Farm		
pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's Ne	me (First, Middle, i	Melden Sume	me)	
Ya	S should be filed with! and Mental Hygiena. a marked other than aumatic event, me M	P		Unknown					Jnknown			
Maryland	d 2 should th and Men 7 is merke traumatic		19e. Informent's Neme/Reletionship (_		tend Number or R				
	feat feat m 2		Jill Zottorelli 20e. Method of Disposition	Guardi				vd, Suite		Stertow 20c. Location		
altimore,	of the		1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific		20b. Plece of came ten			oce)	3/18/98		-	
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lices	Moore	_	Moor	ce Fune	ess of Fecility				
	Physician		23a. Pert1. Enter the diseese, or com shock, or heert failure. List only	plications thet caused to one ceuse on each line	he deeth. Do n	ot enter the	e moda of dy	ing, such es cardia	c or respiretory err	nton,	Maryl	and 21629 Approximete tritervel Between Onset end Deeth
	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting In death)	e	neun	on	ia					lut
	p is	iner		D	ue to (or es e c	onsequenc	oe of):				101	
ó,	cate be executed physician and s the burial-transit	i Examiner	Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury	D	ue to (or es e c	onsequenc	ce of):				1	
κ 68760,	2 p 8	Medicai	that initiated events resulting in deeth) Lest		ue to (or as a co	onsequanc	e of):					
Box	attendir	lan/		d								
o.	the a	Physician/	Pert II. Other significant conditions of	ontributing to death but	not resulting in	the underl	ying cause gi	ven in Pert I.	23b. Did to	obacco use co	ontribute t	to the cause of deat
٥.	ras that tha de signed by the a be detached i	by Phy	Organic Br	am Synd	rome,	Da	ment	70	1 🗆 Y	●● 2□No	3 □ Pro	obably 4 Unkno
of Vital Records,	S S	ompieted							24e. Wes e perfor		6/	Pere autopsy findings vaileble prior to ompletion of causa i deeth?
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>	Q 00 5	2	1 Yes 2 No	Hospitel: 1 Inpatient	t 2 ☐ ER/Out	petient 3	□ DOA Ot	her: 4 Nursing I	Home 5 ☐ Reside	ence 8 🗆 Ot	ther (Speci	ify)
	Attending Ph ir death. ector: Atter th by the funeral		27. Menner of Deeth 1 Naturel 5 □ Panding 2 □ Accident Investigation	28e. Date of injury (Month, Dey		me of jury N	28c. Inju Wo	ry et ork?] Yes 2 □ No	28d. Describe h	ow injury occu	irred	
	5445	Certification:	3 Sulcide 6 Could not by determined	28e. Piece of Injury building, etc.	y - At home, far (Specify)	m, straet, f	actory, offica		28f. Location (S City or Town		iber or Rur	ral Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled	edicai	29a. Certifier (Check only one)	yelclan: To the best of liner: On the basis of e end menner state	xaminetion end	deeth occi for investig	urred et the ti gation, in my	me, dete end plece opinion, death occ	e, end due to lhe c urred et the time, d	euse(s) end m ate end pleca	nenner es s , end due t	steted. to the cause(s)
	To the vithir comp	Me	29b. Signeture end title of certifier	1/1			29c. Licen	se number	2	9d. Deta sign	ed (Month,	Dey, Year)
	. > - 0		1/	()	N		1)4	+7492		3/15.	195	
			30. Neme end eddress of person who	completed cause of dee	oth (Item 23e) (7	Type, Print)					
			Jeffrey T. Denton,	M.D., PO	Box 122	, Gol	ldsbor	, Marvla	nd 21626			
	Sta Registr	ite	31. Dete filed (Month, Dey, Yeer)	32. Registrer	's Signature	L-10		7				



State of Maryland / Department of Health and Mental Hygiene 98

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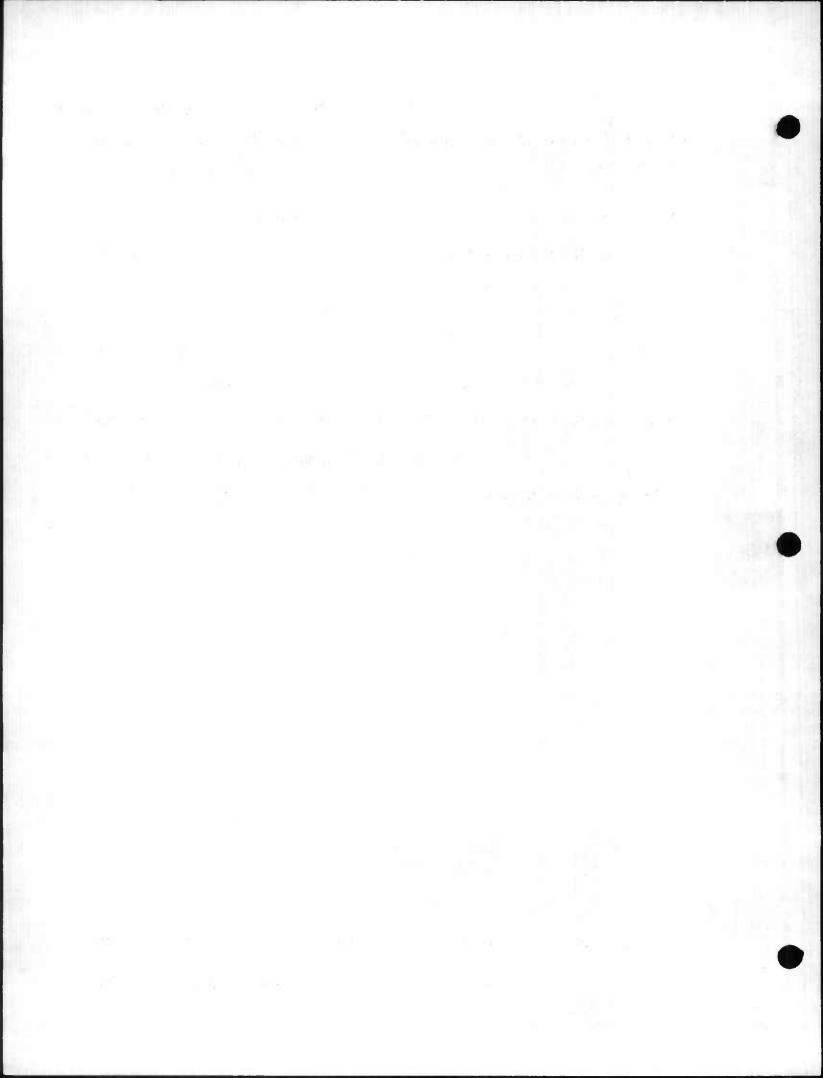
					Certifica	te of	Death			Reg. No.		0100
		1. Decedent's Neme (First, Middle	, Last)						2. Data of De Month			3. Time of Death
Physi /Me	ician dical	ELSA	STAMM	NESSL	ER				MARCH	13,19	98 1	10:35PM
Exam		4a. Fecility Name (If not institution	giva street end number)	TI.		4b. City, To	wn, or L	ocation of Deet			0.3311
		MEDIPLEX 19	301 WATKI	N MILL	RD		GAIT	HER	SBURG	MONT	GOMER	Y
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Directo		560-03-4950	1□M 2XIF	85 Y	rs. Months	Days	Hours	Min.	SEPT.	0,1912	CALI	FORNIA
natural', or items 23a or 28a-1 show		Usuel Residence of Decedent										
show		10a. State 10b. County		10c. City, Town	or Location						10d.	Inside City Lim
13	호	MD MONTO	GOMERY	CHEVY	CHASE							1 Yes 2 1
23a or 28a-f sho	Director	10e. Street and Number			10f. Zi	p Code				10g. Citizen of	Whet Country?	7
23a or		8100 CONN	ECTICUT AV	/E. #121	7 2	0815	5			IIC	7 7	
E 5	Funeral	11. Meritel Status	12. Was Decedant	Ever In U,S.	13. Wes Dece	dent of I-	lispenic Or	igin? (Sp	ecify Yas or No	US - 14. Red	⊃ A. ≿e - American I	Indien,
or items	Ē	1 Never Merried 2 Marri	Armed Forces' ed 1∑ Yas 2 ☐ If Yes, Give				en, Mexicai	n, Puerto	Rican, atc.)	Blee	ck, Whita, atc.	
0.0	þ	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Yaar or Datas:		1 Tes	2 X No	Specify:			Specify	WHIT	ľE
nal hygiene. d other than "natural", or flems event, the Medical Examiner m	2	15. Decedent	s Education	16a. D	Decedent's Usu	ial Occup	etion			16b. Kind of B	usiness/Indust	iry
- 5 9	Completed	(Specify only highes	T		Give kind of wo life. DO NOT u	ork done	during mos	t of work	ing			,
Hygiene. ort, the M	E	Elementery/Secondery (0-12)	College (1-4or 4 YEAR:		NAVAL	OFF	TCE			NAV	VY	
ent,		17. Fethar's Name (First, Middle, L		J				er's Nem	e (First, Middla	, Maiden Sumen	ne)	
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	F	19e. Informent's Neme/Relationsh			Mailino Addres	s (Street				er, City or Town,	State Zin Co.	de)
Tre.		SUSAN FRAMP			_					ERSBURG		
r other		20e. Method of Disposition	- Cit (Dilliot (20b. Piece of D	Disposition (Ne	me of		-	Dete	20c. Location -		
E P		1 Buriel 2 Cremetion		cemetery,	cremetory or	other pla		1				
tant		4 Nonetion 5 ☐ Other (Sp		GEORG					13/98	WASHIN	IGTON,	D.C.
Important: If i any injury or	Succe	21. Signeture of Europe Sarvice L	icensee	2	AUST	nd Addre	ss of Fecili	ty PER	FINED	AL HOME	2	
_ = a	OI	Lewy	attus	fun)						WASH, I		0011
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause	d the deeth. Do no	t enter the mo	de of dylr	ng, such es	cardiac	or respiretory a	rrest,	, Ap	proximete ervel Between
ysicia	n		y 00 00000 000011									set end Death
<i>l</i> ledica	_	Immediate Cause (Final disease or condition	545	STEMIC	SC	Fre	Siz				U	EARS
amine	r	resulting In death)	0.	Due to (or es e co								
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and I-transit	Examiner	Sequentially list conditions	b	Due to (or es e co	nsequenca of)	:						
en ar riel-t		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying			,							
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ed by the deteched	hys	T of the algitime and condition	is contributing to death t	out not resulting in t	ne underlying i	cause giv	en in reiti	١.		tobacco use co		
igned to									10	Yes 2□ No	3 Probabl	ly 4 Unkn
sign d b	d by								24a Wes	en eutopsy	24b. Were	eutopsy finding
peen si	Completed								perfo	rmed?	eveilat	ble prior to etion of causa
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certificate rector, pag	Be	25. Wes case referred to medical exeminer?						of Deat	h (Check only o	one)		
S D	2	1 □ Yes 2 □ √No	Hospitel: 1 Inpati	ent 2□ER/Outp			ACINI	ursing Ho	me 5 Resi	dence 6 Oth	er (Specify)	
After t	ü	27. Manner of Death S □ Pending	28a. Dete of inju (Month, De		na of i	28c. injur Wor	y at k?		28d. Describe	how Injury occur	red	
tor: A	Certification:	2 ☐ Accident investige	etion		М		Yes 2	No				
Director:	Ħ	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicida determin	ned 288. Pieca of in	jury - At home, farm tc. (Spacify)	n, street, fector	y, office			28f. Location (Street and Numb	per or Rural Ro	oute Number,
2 P	Se		ounding, or	io. (opaony)					J., J.	, 5.0.07		
Funeral Cletchy filled	ie.	29a. Certifying	Physician: To the best	of my knowledge, o	deeth occurred	at the tir	ne, dete en	d plece,	end due to the	ceuse(s) and ma	anner as stete	d.
olete	edicai	(Check only	xaminer: On the basis o end menner st	r examination end/ ated.	or Investigetion	n, In my o	pinion, daa	th occur	red at tha tima,	date end place,	end due to the	ceuse(s)
To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signeture and title of certifiar	0				a number			29d. Data signe	d (Month, Day	, Year)
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		30 Name and adverse of some	N D	donth /liam co-1 /*			/			1 A Marc	1 , 1 /	, , ,)
		30. Neme end eddress of person w	no completed cause of o									
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regis	ni ai	MAR 18	330									
A 49	200.00											



				State of Maryla		partment of ertificate of			giene g	8 10140	
			1. Decedent's Name (First, Middle, Last)					2. Date of Date	ath	3. Tima of Death	
,	Physici Medie/			Norman 1	N	ichols,	Sr.	Month March 1	0, 1998	8:40AM	
	Examir		4a. Facility Name (If not institution, giva s THE MEMORIAL HO		EAST	ON		n, or Location of Death 4c. C		County of Death TALBOT	
	Funeral Director		5. Social Security Number 217-30-7768 6. Sax Usual Residence of Decedent		i. last birthde 97 Yrs.	Months Days			/ 1900	9. Birthplace (State or Foreign Country) Delaware	
	with the Maryland as or 28a-f show the notified at	tor	10a. State 10b. County MD Caroli		ity, Town or		eralsbu	rg		10d. inside City Limits 1 ☐ Yas 2☐No	
	h with the 23s or 28 sst be no	ai Director								What Country? States	
020	hours after death with the Marylar hursi", or lisma 23s or 28a-f show al Examinet must be notfiled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas:	U,S. 1:	3. Was Decedent of if Yas, specify Cu 1 □ Yes 2 □ No		(Specify Yas or No- erto Rican, atc.)	14. Race Blac Specify:	e - American Indian, k, White, etc. Black	
1215-0	swithin 72 hours plans, rithan "natural", c	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondery (0-12)	cation a com <i>pleted)</i> College (1-4or 5+)	(Gi	cedent's Usual Occu ve kind of work don b. DO NOT use retire Mer	e during most of w	vorking	16b. Kind of Bu		
Maryland 21215-0020	And the filed view that Hygis fixed other to be swent, the best of the fire of	To Be Co	17. Father's Name (First, Middle, Last) Joh	n Jenkins 1				lame (First, Middle, y Franc	Maidan Sumami		
	and 2 shorestill and 3 section of 27 is man er traume		19a. informent's Neme/Reletionship (Ty) Minnie Whitset							State, Zip Code) 21632 ralsburg, MD	
Baltimore,	Pages 1 nent of He int: If New ury or oth		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, c	position (Name of rematory or other pl 1 Hill (ace) Cemeter	Date y 3/14		City or Town, State	
Balt	Baltim permit. Pa Departmen Important any Injury ance.		21. Signature of Funarai Service License			22. Name and Addi Frampton PO Box	m-Hawki			ral Home	
-	Physician		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea se cause on each line.	th. Do not a	anter the mode of dy	ring, such as card	iac or respiratory ar	rest,	Approximata interval Between Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Congest		heart sequence of):	faile	116		2 9 <0 >)	
	d d ansit	Examiner	Sequentially list conditions	Renal	or as a cons	al lure				29000	
760,	ate be axecuted sysician and he burial-transit	cal Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Cause (Disease or injury that initiated events	COTONOI) A	rtery	disea.	1		10 9 ears	
Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	resulting in death) Last	l.	or as a cons	equence or):					
ω.	death e atte	sicia	Part II. Other significant conditions con	tributing to death but not ra	sulting in the	underiving cause g	iven in Part i.	23b. Dld 1	obacco use con	ntribute to the cause of death?	
s, P.O.	s that the ned by th e detache	by Phys								3 □ Probably 4 ◯ Unknown	
Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed							en autopsy med?	24b. Were autopsy findings available prior to completion of causa of death?	
<u> </u>	The page	Con						101	es 2 No	1 ☐ Yes 2 ☐ No	
Vita	clan:	Be	25. Was case referred to medical exeminer?	ospital:				eath (Check only o	ne)		
on of	ding Physician: The la th. After this certificate has funeral director, page 2	tlon: To	27. Manner of Death 1 Natural 5 Panding 2 Accident Investigation	1 SInpatient 2 D 28a. Dete of injury (Month, Day Year)	28b. Time injury	of 28c. inju		Home 5 Resid	lence 6 Other		
Divisi	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	,	28f. Location (Street and Number or Rural Route Nun City or Town, State)		er or Rural Route Number,				
	the Hospi in 24 hou he Funeri pletely fill.	edical	29e. Certifier (Check only one) 1	ician: To the best of my knier: On the basis of examinand manner stated.	owledge, de etion and/or	ath occurred at the t investigation, in my	time, date and pia opinion, death oc	ce, and due to the curred at the time,	ceuse(s) and mai date end place, a	nner as stated. and due to the cause(s)	
	To t To t	×	29b. Signatura and titla of certifier	MP			ose number			(Month, Day, Year)	
			30. Name and address of person who con Jorge Abrego	mpleted cause of death (ita , M.D., 332	m 23a) (Typ 2 N.	e, Print) Main St	., Fede	ralsbur	g, MD 2	21632	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 '98	32. Registrar's Sign	dion-A	indelle					

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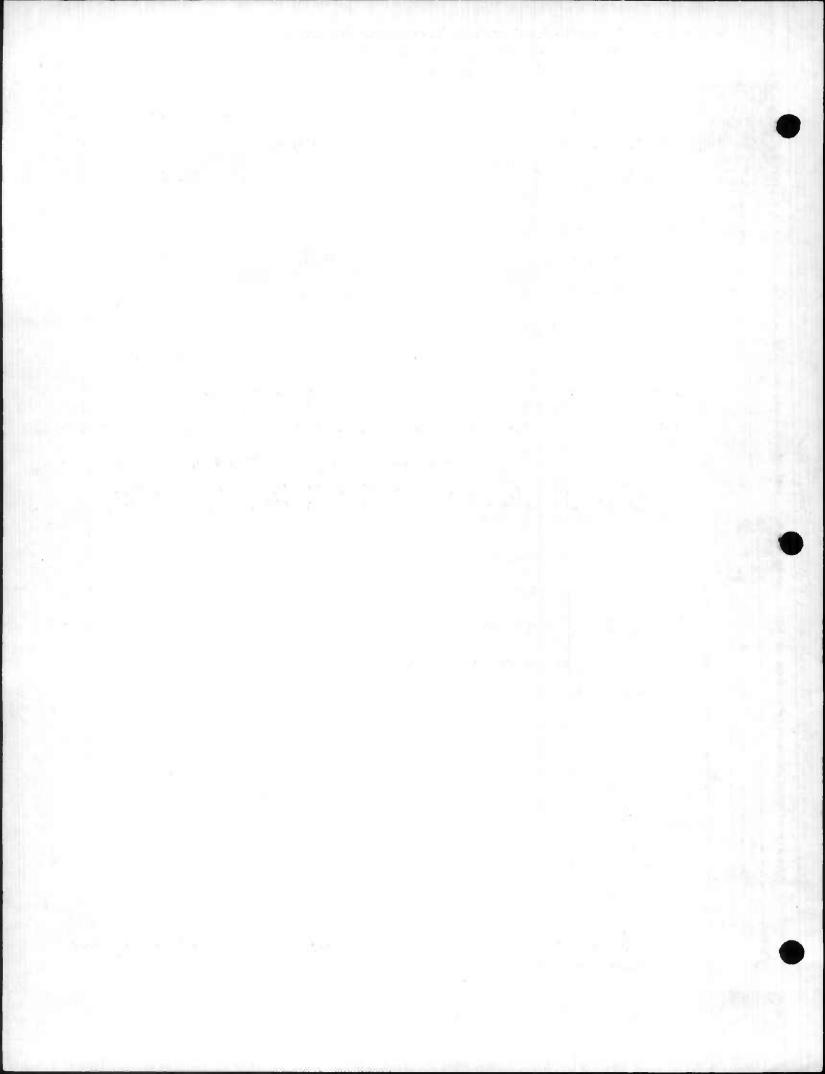
Nichols, Norman Lee



State of Maryla

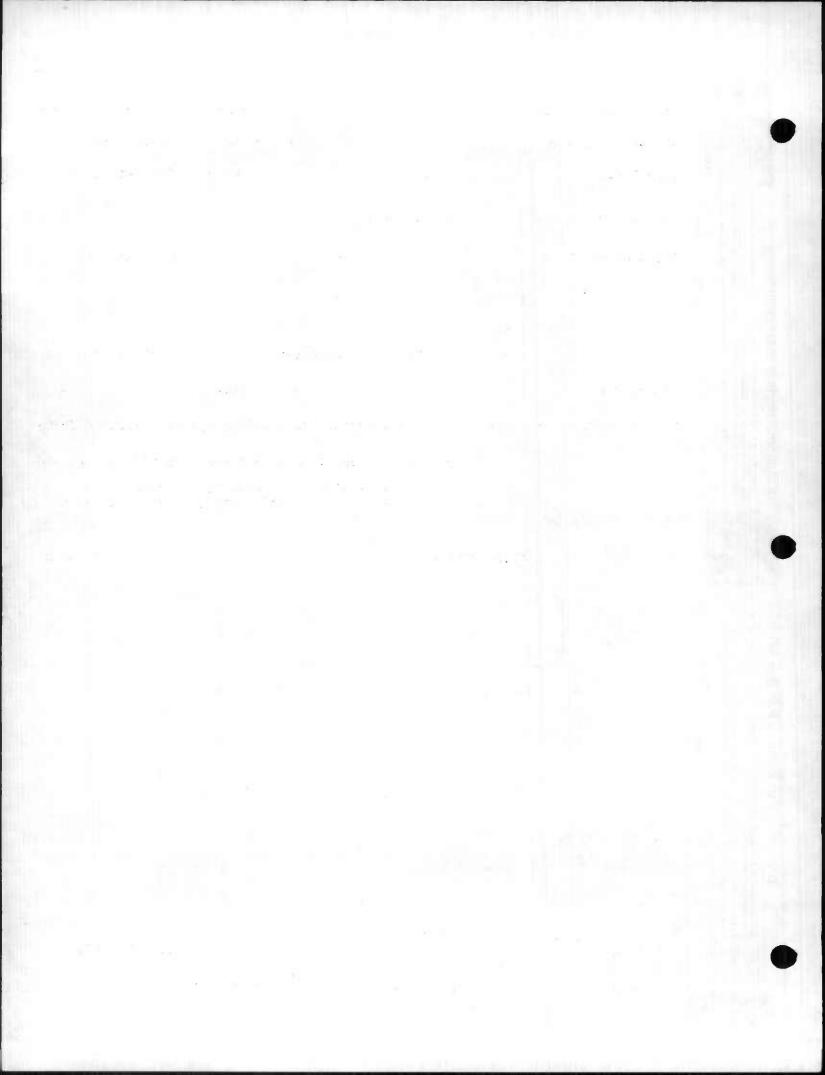
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nd / Department of Health and Mental Hygie	ene 98	1011	, 1
Certificate of Death		101	3 1

		Certificate of Death		Reg.	No.		0141
Dh		Decedant's Nema (First, Middla, Last)	2. Data Mont	of Death		Yaar	3. Time of Death
Physici /Medio	cal	Lulah Virginia Onyun 4a. Facility Nama (If not institution, give streat end number) 4b. City, Town		h 12.	1998 4c. County		5:21 PM
Examir	ner						
Funeral		Suburban Hospital Bethe 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yeer If Under 24	Hrs. 8. Data Min. (Mon	of Birth	Mon	tgome 9. Birthple	TY ace (Stata or Foraign ry)
a or 28a-f show be notified at		219-12-4645 1 M 2 TF 74 Yrs. Months Days Hours Usual Rasidance of Decedent	Apri	1 16	1923		
show stat		10a. State 10b. County 10c. City, Town or Location				10	d. Inside City Limits
28a-f sho notified at	Director	Maryland Montgomery Kensington					1 ☐ Yas 2 ☑ No
	Dire	10e. Street and Number 10f. Zip Coda		10g.	Citizen of V	Vhet Count	ry?
22		3107 Edgewood Road 20895			U.S		
Der must be	Funeral	11. Marital Status 12. Was Decedent Ever In U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, F	n? (Specify Yas Puarto Ricen, at	or No- c.)		a - Amarice k, Whita, a	
Eram.	þ	1 ☐ Naver Merried 2 ☑ Married 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas:			Specify	Whi	te
nedical	Completed	15. Dacedant's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most o	of working	160	. Kind of Bu	usinass/Ind	ustry
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event,	Be C		s Nama (First, M				
is marked other numatic event, I	To	Jesse C. Burns Maude	e V. Pu	rdum			
traumatic	ľ	19a. Informent's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number of			ity or Town,	Stata, Zip	Coda)
or other tra		John E. Onyun (husband) 3107 Edgewood Raod 20a. Mathod of Disposition 1 🖾 Burlal 2 □ Cramation 3 □ Ramoval from State	Kensin	gton,	Maryla Location -	and City or Tov	20895 vn, Stata
ury		4 Donation 5 Other (Specify) Forest Oak Cemetery	3/16/9	8 Gai	Lthers	burg.	Maryland
important: any injury once.		21. Signatura of Funeral Service Licentee 22. Nama and Addrass of Facility Francis J. Collin	na Funa	. 1 II		T	
2 8 0		500 University B	lvd.W.	.Silv	er_Spi	ring.	MD 20901
sician edical		23a. Part1. Epiler the disease or compligations that caused the death. Do not antar the mode of dying, such es ca shook, or heart failure. List only one cause on each line.	ardiec or raspiral	lory arrest,			Approximete Interval Batween Onset end Deeth
aminer	н	Immediate Causa (Final disaase or condition resulting in daath) a. Sepsis					72 Hours
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) physician and ss the burial-transit	Examiner	Sequentially list conditions. Renal Failure Dua to (or as a consequence of):					72 Hours
urial-t	EX	Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Causa (Disaasa or Injury Congestive Heart Failure					Months
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settending physic of for use es the b	ν/Mec	d Coronary Artery Disease					Years
of for i	iciai	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h	Did tobe	CO HEE COL	atribute to	the cause of death?
gned by the ette be detached for	Physician/	The state of the s	200				ably 4½ Unknow
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should t	Completed			performed	17	con	llable prior to
9 hes	dmc			1 🗆 Yas	o Minio		eath?
certificate he rector, page		25. Was cesa referred to medicel	d Dooth (Chack		2 40 NO	10	Yas 2□ No
9	To Be	axaminar? Hospital:	f Death (Check Ing Homa 5 □		s ∈ □Oth	or (Specify)
After this funeral di	L:Ľ	27. Mennar of Death 28a. Deta of Injury 28b. Time of 28c. Injury at		-	njury occurr		
tor: Aft the fur	atic	2 Accident Invastigation M 1 Yas 2 No					
Q >	Certification:	3 ☐ Suicide 6 ☐ Could not be datermined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Loca City	tion (Stree or Town, S	t and Numb tata)	er or Rural	Routa Number,
To the Funeral Directory completely filled in by	edicai C	29a. Cartifler (Check only one) 1. ★ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and processing the control of the best of examination and/or investigation, in my opinion, daath and manner stated.	place, end dua t occurred et the	o the ceus	e(s) end ma and plece, a	nner as sta and dua to	ited. tha ceuse(s)
omple omple	Me	29b. Signatura and titla of certifiar 29c. Licansa number		29d.	Data signed	(Month, D	Pay, Yaer)
. 0		Min a. Dunchen MD 041311			ARCH		
		30. Name and eddrass of parson who complated causa of daath (Item 23e) (Type, Print)			-	, -,	- / 5
		Yuri A. Deychack, 6410 Rockledge Drive, Bethesda,	MD 208	17			
Sta		31. Dete filed (Month, Day, Year) 32. Registrar's Signatura		-			
Registr	ar	MAR 18 1999 July Bavidson-Randale					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** NANCY JANE PALMER March 10, 1998 5:15 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Feclity Name (If not institution, give street end number) Examiner Silver Spring
If Under 1 Yeer | If Under 24 Hrs. | 8. Date 500 Beaumont Road Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Min. Days Months Hours 1 M 20 F Yrs. 56 May 21, 1941 New York Director 132-32-6445 Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits r 28a-f show 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiena. I hours after death with I montant: If item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the second state of the second state o 500 Beaumont Road United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) 12 Technical Director Scientific Association 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Neme (First, Middle, Last) Be Albert Hill Barbara Hurd 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Samuel W. Page - Husband 500 Beaumont Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 3-13-98 Rockville, Maryland 21. Signature of Fungral Service Licensee 22. Name and Address of Fecility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part. Enter the disease, purphications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **GLIOBLASTOMA** 2 YEARS Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): E physician at the bunal P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 1 USO 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed I Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of deeth? page 2 s has certificate 1 Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: funeral director, 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1 Neturel 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) To the To the To the 29b. Signature,and title of certifié 29c. License number 29d. Date signed (Month, Dey, Year) 10 D23540 March 13, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 310 Dr. Hugh Hill, 1450 Research Blvd., Rockville, Maryland 20850 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State whe Davidson Registrar 1998 MAR 16



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dorothy W. Payne March 17, 1998 7:00 PM 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Suburban Hospital Bethesda Montpomery If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) Months Deys 1 ☐ M 28 F 577-01-7463 84 Yes Nov.22,1913 Illinois Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland | Montgomery Rockville 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 11403 Stonewood Lane 20852 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Ear1 Williams Mabel T11iff 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley R. Payne/ Husband 11403 Stonewood Lane, Rockville, MD 20852 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) March 19, 1998 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland re of Funeral Service 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave, Bethesda, MD20814

Approximate
List only one ceuse on each line.

Chase, Inc. 7557 Wisconsin Ave, Bethesda, MD20814

Approximate
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Physician /Medical Examiner

certificate be executed

Box 68760.

P.O.

Records.

Division of Vital

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Physician

/Medicai

Examiner

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Funeral

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Completed

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10a. Stete

Funeral

Director

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2 should be filled within 72 hours aftar daath of and Mental Hygiane.
Is marked other than "natural", or itsms 23

Baltimore, Maryland 21215-0020

with the Marylend

Examiner physician and the burial-transit Physician/Medical use as been signed by that should be deteched þ Completed hes funeral director, Be 20 this or Attending Pisel of the death. Certification: To the Hospital or Atter within 24 hours eftar dar To the Funeral Director completely filled in by th

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1⊠ inpatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion

1 Yes 2X No 1 ☐ Yes 2 ☐ No

2 Accident 6 Could not be determined 3 Sulcide 4 Homicide

28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signeture end title gla

🖾 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month. Dav. Year) 29c. License number

D 07147 March 18, 1998

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

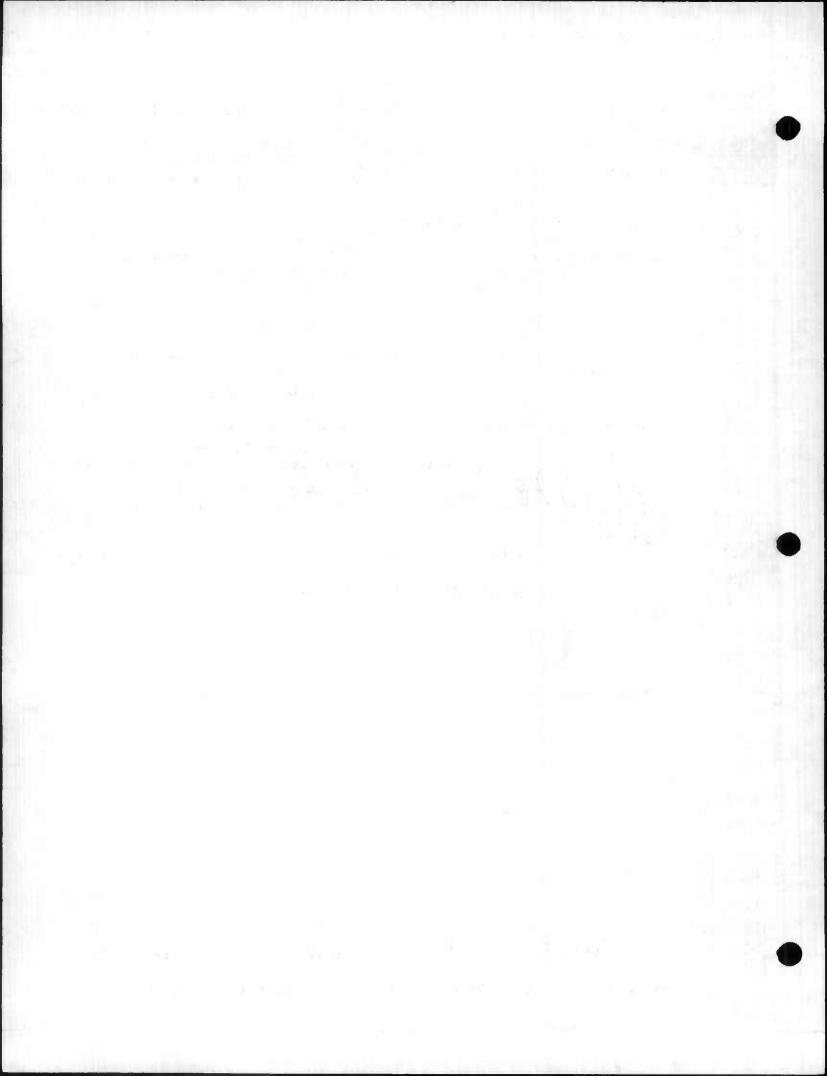
Allen A. Nimetz, M.D. 31. Dete filed (Month, Day, Yeer) MAR 20 1998

29e. Certifier

5401 Western Avenue, NW Washington, DC 20015 32. Registrer's Signeture Litian Davidson Randell

State Registrar

Medical



State of Maryland / Department of Health and Mental Hygiene

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1. Decedent's Name (First, Middle, Las	1)							of Death	1	Year	3. Time of I
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a Facility Name (If not institution, giva	straat and nu	umber)			41	b. City, Town, o			4c. County		
Franklin Square	Hospi	tal Cer	iter			Roseda	le.		Balı	timor	°e
Social Security Number 6. Sa	M 201F	7. Aga (In yrs	s. last birth	hday) If Und Month	der 1 Year	If Under 24 H	R O Date	of Birth		9. Birth	place (State or intry)
280-14-6283	_ M 21∆LF	82	Υ	rs.		NUMBER 1855	Augu	st 23	, 1915		Ohi
Usual Residence of Decedent		100									40.1.1.1.00
10a. State 10b. County		10c. C	ity, Town	or Location							10d. Inside City
Maryland Montgome	ery		Potor	mac							1 🗆 Yes
10e. Street and Number				10f.	Zip Coda			10	g. Citizen of	What Cou	intry?
9603 Falls Road	d				2085	4			United	Sta	tes
11. Marital Status	12. Was Dec	cedent Ever in	U,S.	13. Was De	cedent of His	spanic Origin? n, Mexicen, Pu	(Specify Yes	or No-		ce - Amari ck, White	ican Indian,
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3 X Widowed 4 ☐ Divorced	If Yes, G Year or D			1 🗆 🕇 es	2 2 Z NO	Specify:			Specify	y:	White
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Wi	illiam	Jackso	n Ca	ldwe11		A	deline	Jac	kson		
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John C. Peters/So	nn .		57	16 Chr	is-Mar	Avenue	. C14	nton	. Mary	land	20735
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4 ☐ Donation 5 ☐ Other (Specify,		POU	Lonac								laryland
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumstic event, the Medical Exercise must be notified at once.

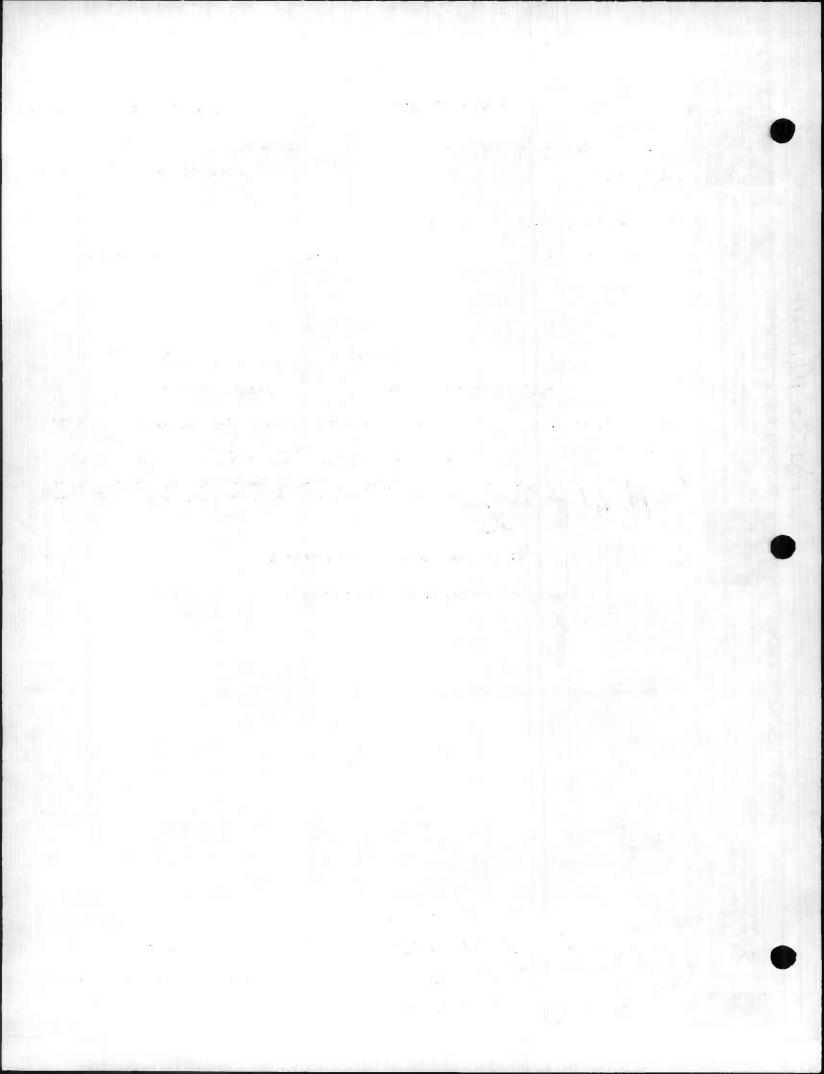
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Peters, Marianne



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Phifer George Н. 1998 March 16, 2:20 PM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01 ney Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 30, 1 If Undar 1 Year 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) Months Days 577-14-7005 83 Vrs Missouri Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3113 Farnborough Court 20906 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 X Yes 2 No 1941 -If Yes, Give Yaar or Dates: 1946 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 1946 White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Broker / Appraiser Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) W. Phifer George Mabe 1 Α. Fox 19a. tnforment's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J Phifer (daughter) 9807 Cottrell Terrace, Silver Spring, MD 20903 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-17-98 Beltsville, Maryland Chesapeake Crematory 22. Nama and Addrass of Facility Rapp Funeral Services, P. A. 21. Signature of Funeral Servica Licardon 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final 13 YEARS disease or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner buniel-trensit pue Division of Vital Records, P.O. Box 68760. ettending physiclan for use es the burie

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be 2

Certification: in by

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To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certific 10

100 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the ceuse(s) and manner as stated.
2 Medicat Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifie 29b. Signature and tille of certified

6 Could not be determined

18 1998

2 Accident 3 Sulcide

4 Homicide

MO 75635

29d. Date signed (Month, Dey, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

DR

OLNEY MO 20837

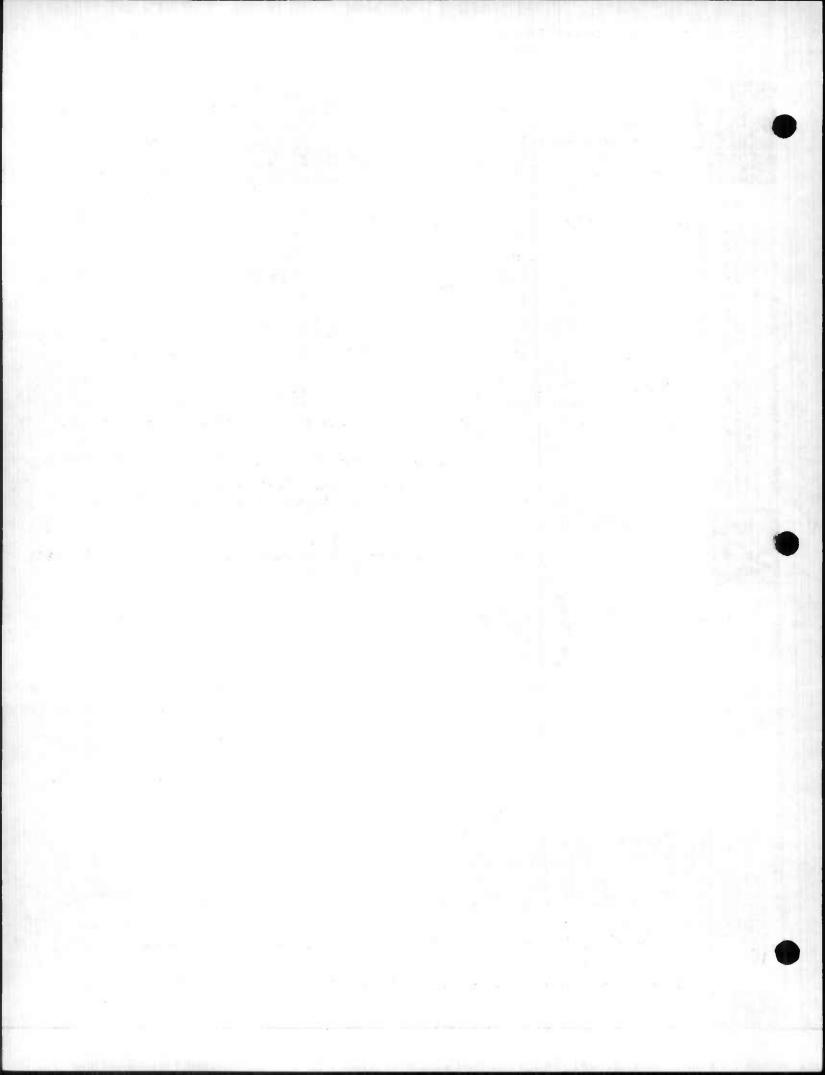
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

31. Date filed (Month, Day, Year) State Registrar

edicai

32. Registrar's Signature Randoll

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1 Decedent's Nama (First Middle Last) 2. Data of Deeth 3. Time of Death Month Day **Physician** Yaar Barbara S. Portmann March 18, 1998 12:05PM /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Sociel Sacurity Number ff Undar 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthdey) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1□ M 2□F Months Days Hours **Yrs** 103-18-2327 Director 1920 Massachusetts Usuel Rasidanca of Dacadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 Yes 20No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 10224 Farnham Drive 20814 United States Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Bieck, White, etc. 1 Navar Married 2 Married 1 Yes 2 No Spacity: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decadent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elemantery/Secondary (0-12) 5+ Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meidan Sumeme) Be George A. Straub Paula Meade 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Pierre A. Portmann/Husband 10224 Farnham Drive, Bethesda, Maryland 20814 20b. Placa of Disposition (Nama of cematery, cremetory or other piece) March 19 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 X Cramation 3 Ramoval from State 1998 5 Othar (Specify) 4 Domation Montgomery Crematorium, Inc. Bethesda, Maryland Funeral Service Dis 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00803 | Bethesda, Maryland 20814-35

23a. Part1. Enter the disaasa, or complications the cusad tha daath. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or haert failura. List only one cause on each line. 20814-3501 Onsat and Death **Physician** /Medical Immediata Causa (Final Acute Myocardial Infarction diseese or condition resulting in death) 40 Hours Dua to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequantially list conditions, if any, leading to Immediate cause. Enter Undarlying Causa (Disease or Injury Dua to (or as a consequenca of): Physician/Medical that initiated avants rasulting in daath) Last Dua to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Acute Cerebrovascular Accident þ 24a. Wes en autopsy parformad? 24b. Wara autopsy findings avelleble prior to Completed Diabetes Mellitus completion of cause of deeth? 2XXNo 1 ☐ Yas 2 No Right Femoral Hematoma Be 25. Wes casa rafarrad to madical axaminer? 26. Placa of Daath (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yas 2 No 1 npatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 X Naturai 5 Pending 1 □ Yas 2 □ No invastigation 2 Accidant 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 6 ☐ Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, data and placa, and dua to tha causa(s) and mannar as stated. Medical (Check only one) 2 Medical Examinar: On the basis of exeminetion and/or invastigation, in my opinion, deeth occurred et the time, dete end place, and dua to the cause(s) and mannar stated. 29b. Signature and title of oq 29d. Date signed (Month, Dey, Year) 29c. License number enry D21115 March 18, 1998 and addrass of person who completed cause of daeth (Item 23e) (Type, Print) Lee R. Pennington, MYD 5602 Shields Drive, Bethesda, Maryland 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura

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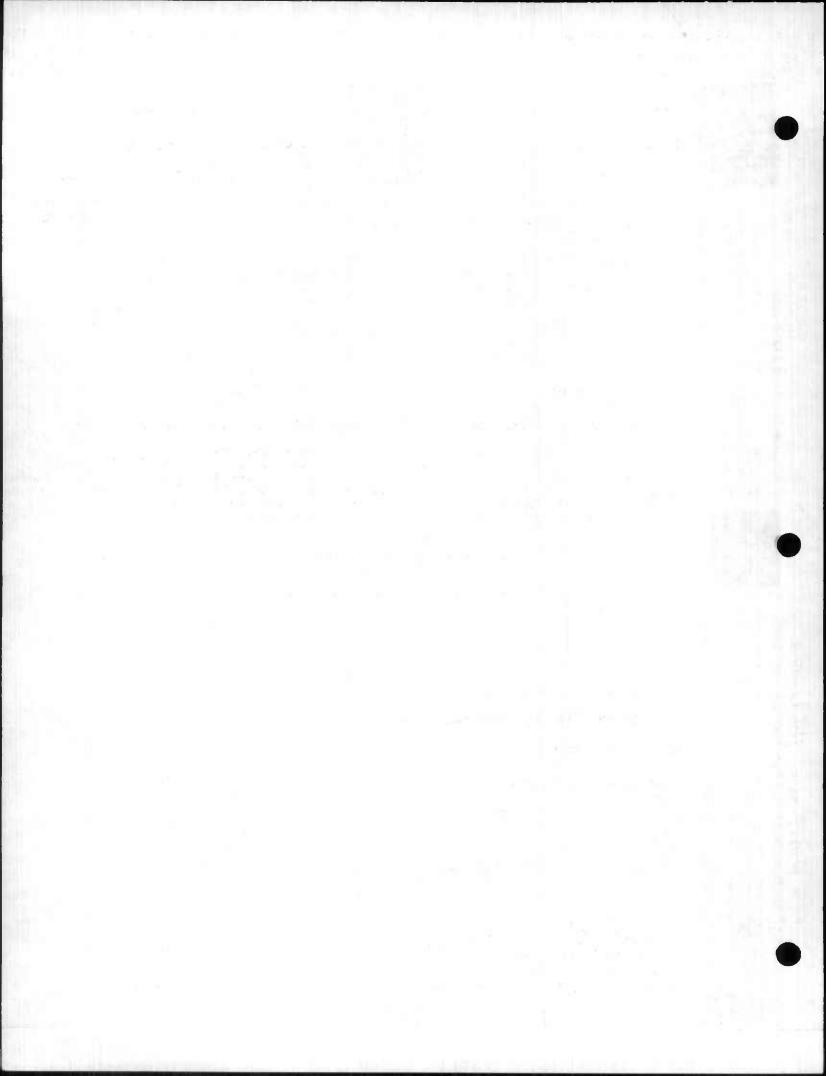
Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

Registrar

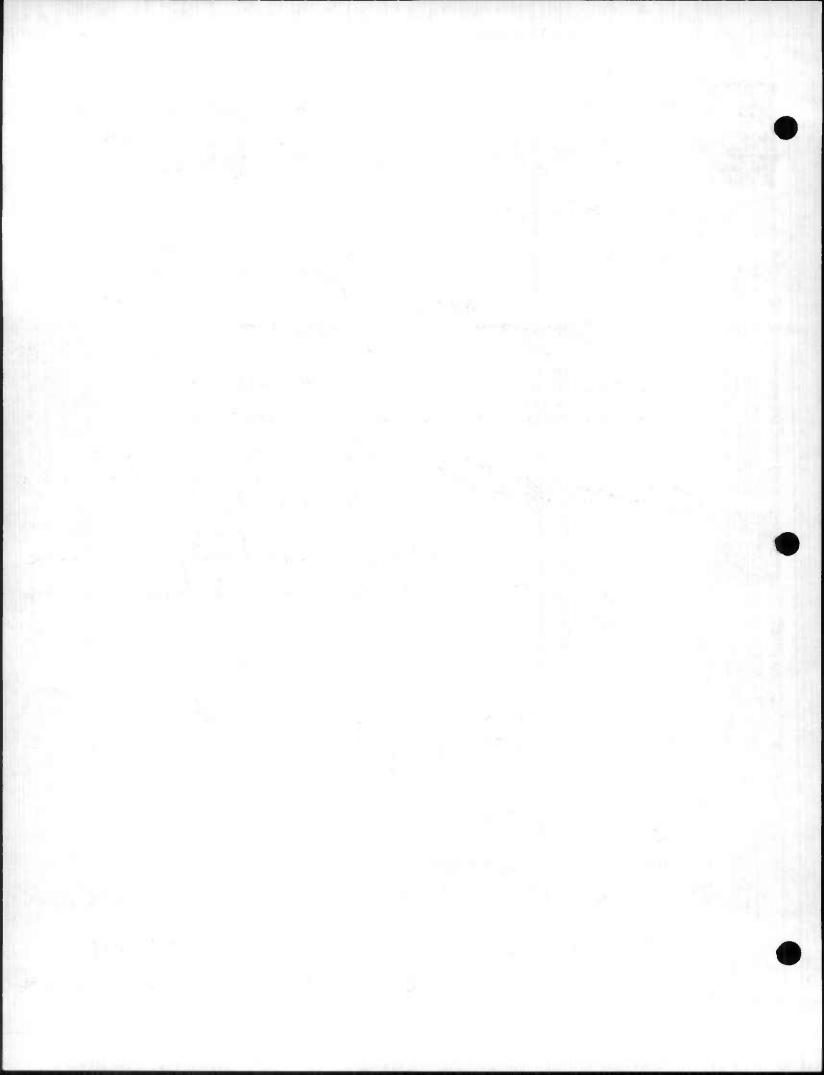
MAR 20 1998

Mia Davidson



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()

			Sta	te of Maryland / D	epartment of r Certificate of		Reg. No.	98 10147
	Physici /Medi Examii	cal	Decedent's Name (First, Middle, Last) BERT 4a. Facility Name (If not institution, give street a	// -	Presc		Date of Death Month Day OARCH / Le on of Death 4c. Co	Year 1998 10:00 Am ountry of Death
	- Addition		Washington Adventis	t Hospital		Takoma Park	Mo	ntgomery
	Funeral Director		5. Social Security Number 393-14-6314 6. Sex	7. Age (In yrs. last birth	nday) If Undar 1 Yaar Months Days	Hours Min.	Date of Birth Month, Dey, Year) C. 9, 1922	9. Birthplace (State or Foreign Country) Wisconsin
	Maryland H show fled at	tor	Usual Residence of Decedent 10a. State MD	rges 10c. City, Town			***************************************	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show cmust be notified at	al Director	10e. Street and Number 8300 26th Ave.		10f. Zip Code 20783		10g. Citize USA	n of What Country?
	hours after death with the Maryta ural", or items 23a or 25a-f show at Examiner must be notified at	by Funeral	1 Never Married 1 Married 11€	s Decedent Ever in U,S. ned Forces? JYes 2 No es, Give ar or Dates: 1941-1945	13. Was Decedant of H If Yes, specify Cub.	dispanic Origin? (Specify an, Mexicen, Puarto Rica Specify:		. Race - Amarican Indian, Black, White, etc. pecify: White
	swithin 72 ho jone. then "nature the Medical.	Completed	15. Decedent's Education (Specify only highast grada comp	leted) 16a. [16a. Decedent's Usual Occupation (Give kind of work dona during most of work life. DO NOT use retired) Logistics			of Business/Industry
and 2	be filed vital Hyg ad other event,	Be	17. Father's Name (First, Middla, Last) Robert Prescott Sr.	208	,	18. Mother's Name (Fit	rst, Middle, Meiden Su	
Mary	of 2 should th and Mee 27 is marks traumatic	To	19a. Informant's Name/Relationship (Type, Pri Una E. Prescott (Sp		Mailing Address (Street 00 26th Ave	and Number or Rural Ro . Adelphi,	oute Number, City or 7	'own, Steta, Zip Code)
Baltimore,	Pages 1 an hent of Heal int: If Isem 2 ary or other		20a. Method of Disposition 1 ☐ Burial 2#☐Cremation 3 ☐ Remova 4 ☐ Donetion 5 ☐ Other (Specify)	I from State cemetery	Disposition (Name of crematory or other plant	Ce)		tion - City or Town, State
Balt	Departs Departs Imports any inju	0	21. Signature of Funeral Service Licensee	1		r Spring, M		1800 New Hampshir
x 68760,	Physician Medical Personal Physician and Physician and Physician and Republican and Republican and Republican and Physician and	Medical Examiner	shock, or haart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that instance overthat resulting in death) Last	Due to (or es a co		suffer.	Dostas	Approximate Interval Between Onset and Death I with 10 years
P.O. Box	t the death by the atter tached for o	Physician/M	Part II. Other significant conditions contribution	ven in Part I.	23b. Did tobacco use contribute to the cause of death			
Records,	aw requires as been sign 2 should be	Completed by	Rund Insu	flicien	e y		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
=	£ ##	S)		1□ Yes	No 1 Yas 2 No
/Ita	cian: setfic actor,	Be	25. Was case referred to medical examiner?			26. Place of Death (Cl	neck only one)	
Division of Vital	or Attending Physisher death. Offsector: Ahar this of in by the funeral din	Certification: To	Natural 5 Pending 2 Accident investigation	Date of Injury 28b. Tie	me of ury 28c. Injur	4 LI Nursing nome	5 Residence 6 Describe how injury of	
Divi	ital or Attenurs after dest ral Director: illed in by the		3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office		Location (Street and I City or Town, State)	Number or Rural Route Number,
	To the Hospital o within 24 hours at To the Funeral Di completely filled in	Medical	(Check only 2 Madical Examiner: On an	To the best of my knowledge, the basis of examination and/ d mannar statad.	or investigetion, in my o	pinion, death occurred a	t the time, date and pl	lace, and due to the cause(s)
)	5+1		29b. Signatura and title of certifier First M Curry Carry Carr	1		7966 (N	10) 3	16 / 78
		•	30. Name and address of person who complete CITH M. LIM 31. Date filed (Manh Pay, Year)		ype, Print) 7600	Carrol	Avens	Takomlark
	Sta Registr		MAR 20 1998	This Davidson The	indelle			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26 WCHD 3/25/98 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month 3 MARGARET 1340 1998 4a Facility Neme (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth If Under L.S.R.U.R.Y. Lete of Birth (Month, Dey, Year) PENINSULA REGIONAL MEDICAL CENTER (clel Security Number | 6. Sex | 7. Age (in yrs. lest birthdey) WICOMICO State or Foreign If Under 1 Year 1 □ M 2 □XF Months Deys Yrs 214-10-7043 84 8/9/13 Maryland Usuel Residence of Deceden 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits Wicomico Maryland Salisbury 1 ☐ Yes 2 ☐ No 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of Whet Country? 222 S. Clairmont Drive 21801 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indian, 11 Marital Status Bieck, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) William T. Leonard Mattie Windsor 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Furman Richardson/Son 611 N. Pinehurst , Salisbury, MD 21801 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriei 2 ☐ Cremetion 3 ☐ Removei from State Wicomico Memorial Park 3/12/98 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Poneral Service License 22. Name end Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 outer Paul . Enter the disease, or complications that caused the book, or hear failure. List only one ceuse on each line. Do not enter the mode of dying, such es cerdiac or respiretory errest, Approximate Intervei Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 20116 1 Yes 1 TYes 26. Piece of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpetient 28d. Describe how Injury occurred 28b. Time of

Physician /Medical Examiner

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29e. Certifier

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After this certificate or Attending Physician: death. efter death Director:

Margaret Phillips 214-10-7043

25. Wes cese referred to medicel examiner?

1 Yes 2 No 27. Menner of Deeth

5 Pending Investigation

1 Neturai 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Dete of Injury (Month, Dey Year)

28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. fnjury et Work?

1 ☐ Yes 2 ☐ No

Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end msnner as steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature an

29c. License numbe

29d. Date signed (Month, Dey, Year)

eted ceuse of deeth (Item 23e) (Type, Print) 30. Name and addes of person Merrill M.D 100 PONEX

31 Dans filed (Month, Dey, Year) MAR 12 1998 32. Registrer's Signeture

State Registrar

24 hours e

within 2 To the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) marcin 072 1998 10 Garnie Algarve Polson 4a Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 6. Sax 1 M 2 ☐ F If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 7 19 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1917 N. Carolina 229-16-04 6. Usual Residence of Decedent 63 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Salisbury 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S.A 14. Raca - American Indien, Black, Whita, etc. 21801 13. Was Decedent of Hispanic Origin? (Specify Yas or Nolt Yas, specify Cuban, Mexican, Puerto Rican, atc.) 608 Morris Street 12. Was Decedent Evar in U,S. Armed Forcas? 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: ₩ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Alexander Polson Etta Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Morris Street Salisbury, Md. 2180 1 ce of Disposition (Nama of Date 20c. Location City or Town, State Sarah Polson (Wife) 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from State 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 4 □ Donation 5 □ Other (Specify) Hebron, Md. Springhill Mem.Garden 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Stewart Funeral Home Stewart Funeral Home 821 West Rd. Salisbury 23a. Part1. Enter the dis rase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart teil/re. List only one cause on each line. 821 West Rd.Salisbury, Md. 21801 Approximete Intervel Between Onsat and Death Immediata Cause (Final diseese or condition resulting In deeth) HYPOXIC ENCEPHALOPATHY Due to (or es a consequence ot): STATUS EPILEPTICUS Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury thet Initieted events resulting in death) Last Due to (or as a consequence ot): CERIBRO VASCULAR DISEASE Due to (or as a consequence of): 23h. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 DOnknown OF PREDIOOS PERSONAGE DELIDENT 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? FACTOR VIII I ENDENCY 20 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how triury occurred

physician and s the burial-trensit use es t Division of Vital Records, certificate this funeral After or Attending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Physician

* /Medical

Examiner

Directo

Funeral

by

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Examiner

Physician/Medical

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Completed

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item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumstic event, the Medical Examinar must be notified at

d 2 should be filed within 7 th end Mental Hygiena.
7 Is marked other than "r

permit. Pages 1 end 2: Department of Health et Important: if item 27 ls any injury or other traupings.

Physician

/Medical

Examiner

with the Marylend

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Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

27. Manner of Death 5 Pending Investigation 1 PNatural 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Yes 2 No

28e. Placa of Injury - At home, ferm, straat, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.

29b. Signature and title of cartifier

29a. Certifie

(Check only one)

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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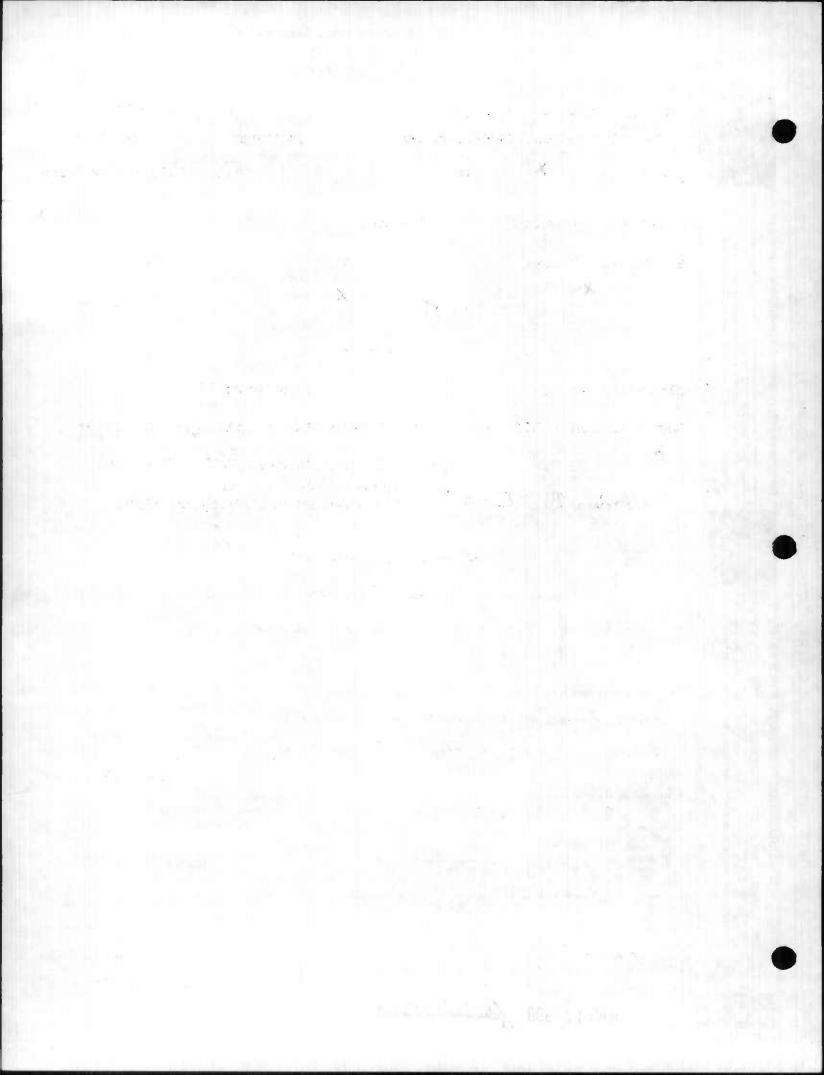
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

106 PINE BAUFF ROSAITE 12 SPAISBURY, MO 2180 MO dames h. CHIFEBRO 31. Date tiled (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

Julia Davelson Randall MAR 1 2 1998

To the Hospital

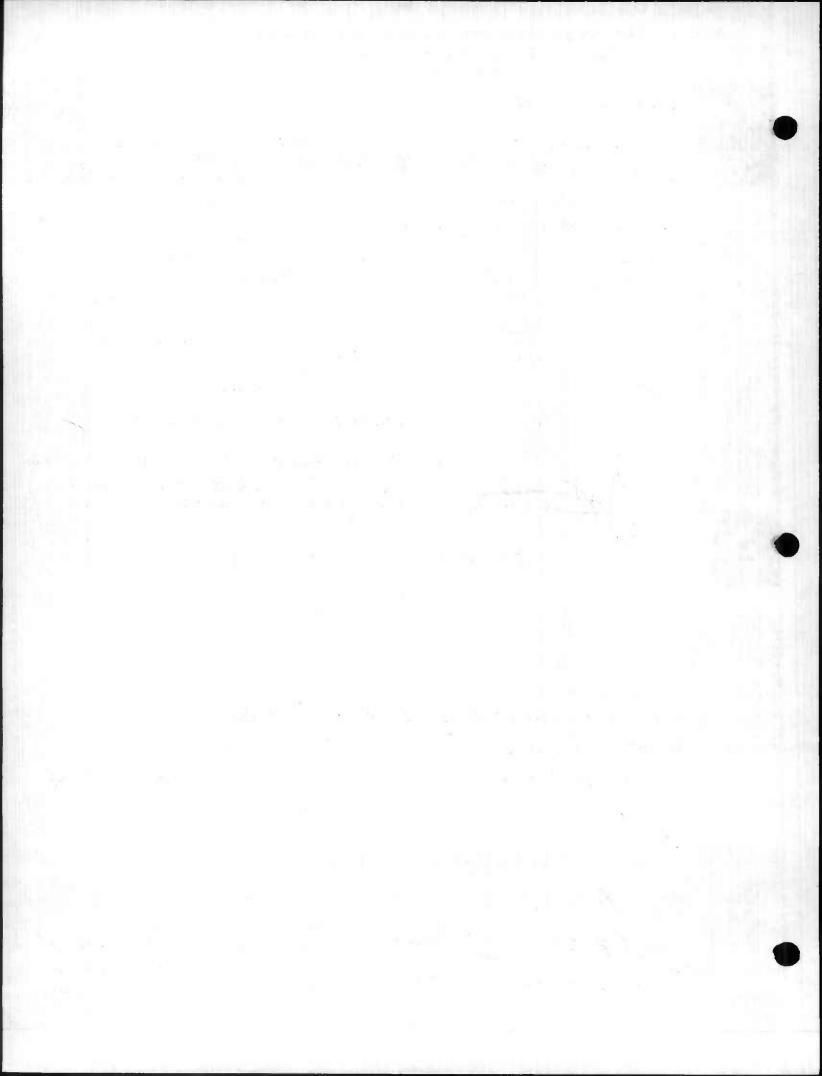


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death Month **Physician** RICHARD HARRY PARRISH MAR. 6, 1998 2:35A.M. /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESAPEAKE HEALTH CENTER ARNOLD ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1**X** M 2□ F Yrs **Director** 201-20-3928 70 MICHIGAN MAY 8, 1927 Usuel Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 238 1841 CEDAR DRIVE 21144 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgln? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify. Specify: WHITE ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CIVIL SERVICE Elementary/Secondary (0-12) College (1-4or 5+) 12 DIESEL MECHANIC US-ARMY 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY ANN PARRISH 1841 CEDAR DRIVE SEVERN, MARYLAND 21144 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 3/7/98 BELTSVILLE, MARYLAND CHESAPEAKE CREMATORY, INC. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. est 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 2106 I SECOND AVENUE, S.W. GLEN B or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ilure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Finel disease or condition resulting In death) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last end Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical the Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? yd bengis 2□ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24a. Was en eutopsy performed? hes bone metastases, this certificate or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No
27. Manner of Deeth
Neturel 5 Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred After Neturei 2 Accident 5 Pending To the Hospital or Attendin within 24 hours efter deeth. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

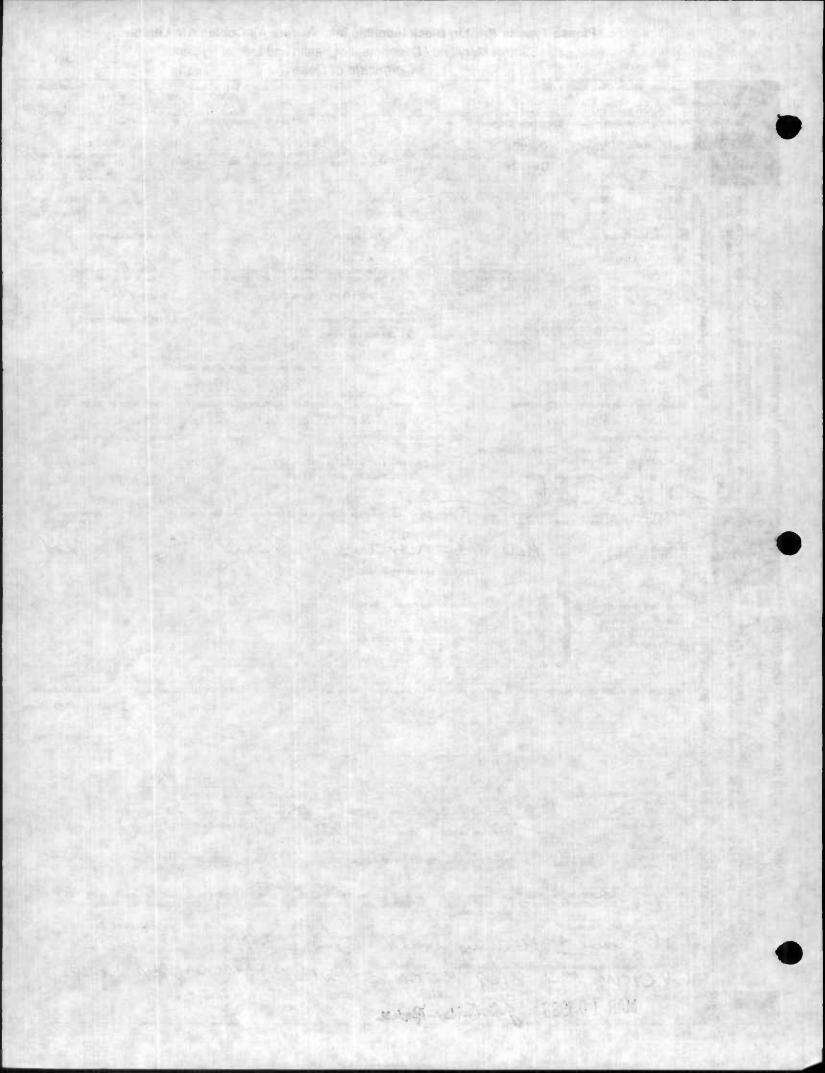
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number Peninsula Farm Rd Arnold MD Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 273B RCC 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Sia Davidson MAR 10 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9

					Certificate	e of	Death			Reg. No.			
		1. Decedent's Nama (First, Middle, La	st)	espliquid	illi ess	10	A TE		2. Dete of De	ath	V	3. Time of Death	
Physi /Med		THOMAS ANTHONY PR	ISCILLA.	SR.					Month MARCH	8. 1998	Yaer 8	11:30PM	
Exam		4a. Facility Neme (If not institution, give street end number)					4b. City, To	wn, or Loc	cation of Death		ly of Death	11.50111	
	411	KNOLLWOOD NURSIN	G HOME				GLEN		IE	ANNE	ARUNI	DEL	
Funera		5. Sociel Security Number 6. S	Sex 7. Ag	ge (In yrs. last birth	Months	1 Yaar Deys	If Undar Hours	24 Hrs. Min.	8. Dete of Birt (Month, Da	h y, Year)	9. Birthp	olece (Stete or Foreign	
Directo	r	167-22-3658 Usuel Residence of Decedent	IDM SUF	70 Y	rs.							CASTLE, PA.	
yland		10e. State 10b. County 10c. City, Town or Location									1	Od. Inside City Limits	
death with the Maryland ms 23s or 28s-f show rms. be notified at	ctor	MARYLAND ANNE ARU	NDEL	GLEN BU	RNIE							1 ☐ Yes 2X No	
or 28	Director	10e. Street end Number			10f. Zip	Code	100		346.3	10g. Citizen of	Whet Cour	ntry?	
ath w		4 WESTDALE ROAD		MESS	210					U.S.	the second second second		
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2 P P P		15. Decedent's Ed (Specify only highest gre	ducation		Decedent's Usue (Give kind of wor life. DO NOT us	Occus	petion	a of modeli		16b. Kind of I	Business/In	dustry	
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and 2 s saith an n 27 is iner traum													
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altin	d	21. Signature of Fundral Registron Fundral Registron Fundral Hon											
Ba Comp	B	1 SECOND AVENUE, S.W. GIEN BURNIE, MARYLAND 210											
		23a. Part1 Enter the disease, or com shoot, or heart failure. List only	plications that cause one cause on each I	d the death. Do no							,	Approximete Intervel Between	
Physicia	1000				2 .			0	,			Onset and Death	
/Medica Examine	-	Immediate Cause (Final disease or condition resulting in death)	Metast	one (ercu	DC	4	/w	me			17201	
		Transiting in deality		Due to (or as a o							- 16		
D8 75	Examiner		b	0									
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artifica fing ph	Med												
Bo Bouth o alter us	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death											
The d	hysi	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlying or	uuse gi	ven in Part I		23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow				
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C 2 25	Com								101	Yes alkno	11	□Yes 2□No	
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Physics of the control of the contro	2	1 [] Yes 2 [] No.	Hospital: 1 D Inpati		The second secon	A				dence 6 🗆 O		M	
	ion	1 Manper of Death 1 Matural 5 Pending	28a. Date of Inju (Month, De		me of 2		ry at rk7 Yes 2	State 1	18d. Describe I	how injury occ	arred		
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To the Hospital of within 24 hours a To the Funeral D completely tilled i		29a Certifier 1 Certifying Ph	yelclan: To the best	of my knowledge,	deeth occurred	et the ti	me, date en	nd plece, e	and due to the	cause(s) end r	nenner es s	iteted.	
he Hos n 24 h he Fun pletoly	edical	(Check only 2 Medical Exam	niner: On the basis o	of examinetion end aled.	or Investigetion,	in my o	opinion, dee	th occurre	ed et the time,	date and place	e, end due t	o the cause(s)	
To We mos	2	296. Signature and title of certifier		. 6	290	. Licens	se number	0		29d. Dete sign	ed (Month,	Day, Year)	
	1 8	> Wtymae M)		- Britannian	de .	D	216	84	1	3.	7.	78	
	18	30. Name and address of person who	completed cause of o	death (Item 23e) (T	Type, Print)	1421	27	DAS	ADEN	3. 1A, M	020	122	
						0,00	, /			/			
Regis	tate trar	31. Dete filed (Month, Dey, Year) MAR 1 0 199	8 Julie	rar's Signatura Davidson-Pa	nder								



State of Maryland / Department of Health and Mental Hygiene ()

Items:15,16a,19a per F.H.G-761 7/27/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Louise C. Pugh 1998 March 14 5:27 am /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham
If Under 1 Yaar If Under 24 Hrs. Prince George's 6. Sax Birthplece (Steta or Foreign Country) 5. Sociel Sacurity Number 7. Age (In yrs. lest birthdey) **Funeral** 10 M 20 F Deys Hours Yrs Director 86 579-34-5963 North Carolina Usuel Residence of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner roust be notified at 1X Yas 2□No Director Md. Landover 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò items 23a 2439 Kentvillage P1. 20785 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 ☐ Navar Married 2 ☐ Married 21215-0020 6 1 ☐ Yes 2 No þ Specify: Black 3 ☑ Widowed 4 ☐ Divorced "natural". Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than *r Elamentary/Secondary (0-12) Collaga (1-4or 5+) N/A 4th Unemployed Cook years Maryland 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumeme) Be permit. Peges 1 and 2 should be Department of Health and Mental Important: If flam 27 is marked c any liury or other traumatic even 2016. To Mammie Lock

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Matthew Cotton 19a. Informant's Name (Felationship Type, Print)
HERBERT G. JONES, Jr./son 2439 Kentvillage Pl Landover Md 20785 George Jones Baltimore, 20b. Place of Disposition (Neme of cemetery, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Denation 5 □ Other (Specify) Harmony 22. Name and Address of Facility 3/21/98 Landover 21. Signature of Funeral Service Licenses Ralph Williams Funeral Service 517 11th St., S.E. Wash., D.C. 20003 Part Enter the disease, or complications that ceused the death. Do not enter the moda of dying, such as cerdlec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final CARDIOPULMONARY IMMEDIATE disease or condition rasulting in deeth) Examiner Due to (or as a consequence of): 2 YEARS 15 CHAEMIC HEART The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Causa (Disease or Injury that initieted events resulting In death) Last and Due to (or es e consequence of): nding physiclen ause as the burial Division of Vital Records, P.O. Box 68760, CORONARY ARTERY DISEAST Physician/Medical Due to (or as a consequence of): signed by the et Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 DUnknown 1 Yes 2 No by 24e. Wes en eutopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed After this certificate 1 Yas 2 No 1 TYes 2 No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 Yas 2 No Dete of Injury (Month, Day Year) 27. Mannas of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accidant after death 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital of within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta and place, end due to the causa(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and titla of certifier 29c. License number 29d. Deta signed (Month, Day, Yeer) Marrew D47604 30. Nama and eddress of person who complated cause of death (Itam 23a) (Type, Print) 7404 EXECUTIVE PLACE SEARROOK, MD 20706 MATHEN MD 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State MAR 2U Registrar

DHMH 16 Rev 6/95

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/Medie		CHRISTINE B 4a. Facility Name (If not institu		PUGH e street and numbe	er)				4b. City, Town, or L	Marc ocation of Da		y of Death	12:30am
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Funeral Director		5. Social Sacurity Number 233-22-5536 Usual Rasidanca of Decedant	6. S	ex □M 2\1 F	Aga (In yrs 80	. last birthde Yrs.	Months	Deys		8. Data of E (Month, I FEB •	Dev. Yeer)	9. Birthpl Count WEST	aca (Stete or Foreign try) VIRGINIA
yland		10a. Stata 10b. Cou	nty		10c. C	ity, Town or	Location					10	Od. Inside City Limits
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<u> </u>	by Funeral	11. Maritel Status 1 □ Navar Marriad 2 □ N 3 □ Widowed 4 ☒ Divorce		12. Was Deceda Armed Forca 1 Yes 2 If Yas, Giva Yaar or Date	s? ∑No	J,S. 1	If Yes, spe	cify Cub	Hispenic Origin? (Spen, Mexican, Puerto Specify:	Rican, atc.)	Bie	atc.	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelih and Mentel Hygiena. Important: If item 27 is merked other than "natural", or ite any injury or other traumatic event, the Mexical Example and Dece.	Completed	15. Dece (Specify only hig Elementery/Secondary (0-12	hest gre		or 5+)	16a. De (Gi	16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busina					Businass/Ind	lustry
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imore, Maryland Peges 1 end 2 should be fill hent of Heelih and Mentel H nt: If them 27 te marked out	L C	19a. informant's Name/Ralation				19b. Ma	iling Addras	s (Street	t end Number or Rui			, Stete, Zip	Code)
end 2		CAROLYN C. STA	NCL:	IFF, NIEC	CE	5603	LANH	AM S	TATION RO	AD, LA	NHAM, MA	RYLAN	D 20706
Baltimore, semil. Peges 1 et Deportanti il flem comportanti il flem con in injury or other note.		20a. Mathod of Disposition 1 X Burial 2 ☐ Cremetic	n 3 🗆	Ramoval from Sta		Place of Dis cemetery, c	position (Ne remetory or	me of other pla	ce)	Data	20c. Location	- City or To	wn, Stata
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Bal permi Depa Impo		21. Signatura dy Funarai Servi	cercicen	He O			FORT	LINC	ass of Facility OLN FUNER	AL HOM	E		
Physician /Medical Examiner		23a. Parf . Enter tha diseese, shock, or haart failura. L' Immediate Ceusa (Final diseasa or condition resulting in death)	or comp ist only	one ceusa on aach	lina.	is	enter the mo		ng, such es cardiec	or respiretory	arrast,		Approximata Interval Batween Onset and Death
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thett	by Ph									1[Yee 2 No	3 Prob	ably 4 Unknown
aw requi	Completed b							-		24a. Wa	as an autopsy formad?	con	ra autopsy findings ilabla prior to nplation of cause leath?
f Vital Roystolen: The last secutificate had director, page	Com									10	Yas 2 No	1□	Yas 2□ No
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Sion o tending Ph eath. for: After th	atlon	1 Netural 5 ☐ Pan	ding stigation	(Month, E	Day Yeer)	Injur	м	28c. Inju Wo 1 □	rk? Yas 2□No	200. 000010	e now injury occu	1160	
Division at or Attendiss after death	Certification:	3 ☐ Sulcida 6 ☐ Cou	ld not be mined	Zoa. Place of t	Injury - At h etc. <i>(Speci</i>	oma, farm,	street, factor	y, offica		28f. Location City or T	(Street end Num own, Stete)	ber or Rural	Route Number,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it	edicai	29a. Certifiar (Check only one) Certification (Check only one)	ring Phy at Exam	velcian: To tha besing and mannar	of my kno of axamina steted.	owledga, da atlon and/or	ath occurred Invastigation	at the ti	ma, data and place, opinion, daath occur	end dua to th	e cause(s) end m a, deta and placa,	enner es ste , and due to	eted. tha cause(s)
To to to com	M	29b. Signatura end titla of carti	No	1					sa number - 1787 -	4	29d. Date signe		
(6)		30. Nama and address of persons S - M - NAYA	R,	mb 3	f daath (Itar 7/7 -	38 A	e, Print)	OTT	AGE CI	TY,	MD	207	722
Sta Registr		S-M-NAYA 31. Data filed (Month, Dey, Ye. MAR 17	1998	33-Regis	tun's Sign	ar Rade	et						

WAR AND THE TOTAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** GEORGE NHHER Month March 15, 1998 12:51 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Sociel Security Number 6. Sex XXM 2□ F 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Yrs. Director 578-50-2798 1938 Washington, D.C. Usuel Residence of Decedent the Marylend 10e. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Fort Washington 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 20744 U.S.A. 13109 Fort Washington Road Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 □XYes 2 □ No
If Yes, Give
Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) 12 Federal Government Building Engineer 17 Fether's Neme /First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Peges 1 end 2 should be fill ment of Health end Mental Hant: If Item 27 Is marked oth lary or other traumatic even Be Forest C. Plummer Plummer Virginia E. Tompkins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 13109 Ft. Washington Rd., Ft. Washington, Md. 20744
of Disposition (Name of Dete 20c. Location - City or Town, State Rita M. Plummer/Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State permit. Pege Department of Important: If any injery or 4 ☐ Donetion 5 ☐ Other (Specify) Trinity Memorial Gardens 3/19/98 Waldorf, Maryland 22. Neme end Address of Fecility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Coations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, appropriate on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner 130 Physician/Medical Examir The law requires that the death certificate be executed ician and burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting In deeth) Lest Due to (or es e consequença of) AZCINOMA P.O. Box 68760, the Due to (or es e consequence of) use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown chose igned t Records, þ page 2 should 24b. Were eutopsy tindings avelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospitāl: ↑☑npatient 2☐ER/Outpetient 3☐ DOA To the Hospital or many within 24 hours after death.
To the Funeral Director: After this of mandalely filled in by the funeral directors of the funeral directors. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Menner of Deeth 28e. Dele of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2. Accident 6 Could not be determined 3 Suicide Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29b. Signature end title 29c. License number 29d. Date signed (Month, Dey, Year)

8

7801 Surratts Rd.#303, Clinton, Md. 20735

Registrar

30. Name end adduss of person who completed cause of deeth (Item 23a) (Type, Print) ROVER

Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7,3/18/98, BMW, Montq. Co. Certificate of Death 3. Time of Death 1 Decedant's Nama (First Middle Last) 2. Data of Death Month **Physician** 2-00 AM MARCH SARAH THEMPER PORTNOY 1998 14 **€** //Medical 4b. City, Town, or Location of Daath 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington 7. Age (In yrs. last birthdey) | H Undar 1 Yaar | H Undar 24 Hrs. | 8. Data of Birth | (Month, Day, Year) | 9. Birthplaca (State or Foreign Country) | Nov. 24, 1917 | Connecticut **Funeral** 1□ M 2□WF 045-187-324 Director Usuel Rasidance of Decedent with the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Maryland 1 Yas 2 No Montgomery Kensington Directo 10f. Zip Coda 20895 10e. Street and Number 10g. Citizen of What Country? I is marked other than "naturel", or items 23a or treumatic event, the Medical Examples must be a 3609 Dupont Ave. U.S.A. 2 should be filed within 72 hours efter death and Mental Hygiene.
Is marked other than "naturel", or frems 23. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No
If Yas, Give
Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Public School Elementary/Secondary (0-12) Teacher 5+ permit Pages 1 end 2 should be file Department of Heelth and Mental Hy, Important. If Item 27 is marked other any injury or other treumatic event, 18. Mothar's Nema (First, Middle, Meiden Surname) 17. Fether's Name (First, Middle, Last) Barnett Themper Minnie Shapiro 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Daughter Mindy Azra Portnoy 20895 3609 Dupont Ave., Kensington, Maryland 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removel from Stata Conn. Lodge Cemetery3/16/98 Connecticut 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Addrass of Facility
Ives-Pearson Funeral Homes at Significant of Funeral Service Licer 2847 Wilson Blvd., Arlington, Va. 22201 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intarvel Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition rasulting in daath) ADRTIC STENOSIS MONTHS Examiner Dua to (or as a consaquanca of): Examiner The law requires that the death certificate be executed physician and the burial-trensit Sequentially list conditions, if any, laeding to immadiata cause. Enter Undarfying Causa (Disaasa or Injury that Initiated avants resulting in deeth) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequanca of): Part il. Other afgnificant conditions contributing to deeth but not resulting in the undarlying causa givan in Part f. 23b. Did tobacco use contribute to the cause of death? ed by the detached Division of Vital Records, P.O. signed by to 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown PLEUPAL EFFUSSION þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy parformad? Completed peen complation of causa of death? has certificate l 1 Yas 2 No 1 Tes 2 No al or Attending Physician: T safter death. I Director: After this certificat 25. Was casa rafarred to medical axaminar? Be 26. Place of Daath (Check only one) Other: 4 vursing Homa 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No After this funeral 27. Manner of Daath 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Certification: 5 Panding Invastigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) in by 4 - Homicide 24 hours a Hospital 1 🖵 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data end plece, and dua to tha causa(s) and mannar as stated. 29a, Cartifiar edical (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) within 2 To the 29b. Signetura end titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) P. Telwas, MD D 36552 1998 12 MARCH 14 30. Name and eddress of person who complated cause of daeth (Item 23e) (Typa, Print)

State Registrar 7. TALLAR (Month, Day, Year) MAR 18 1998

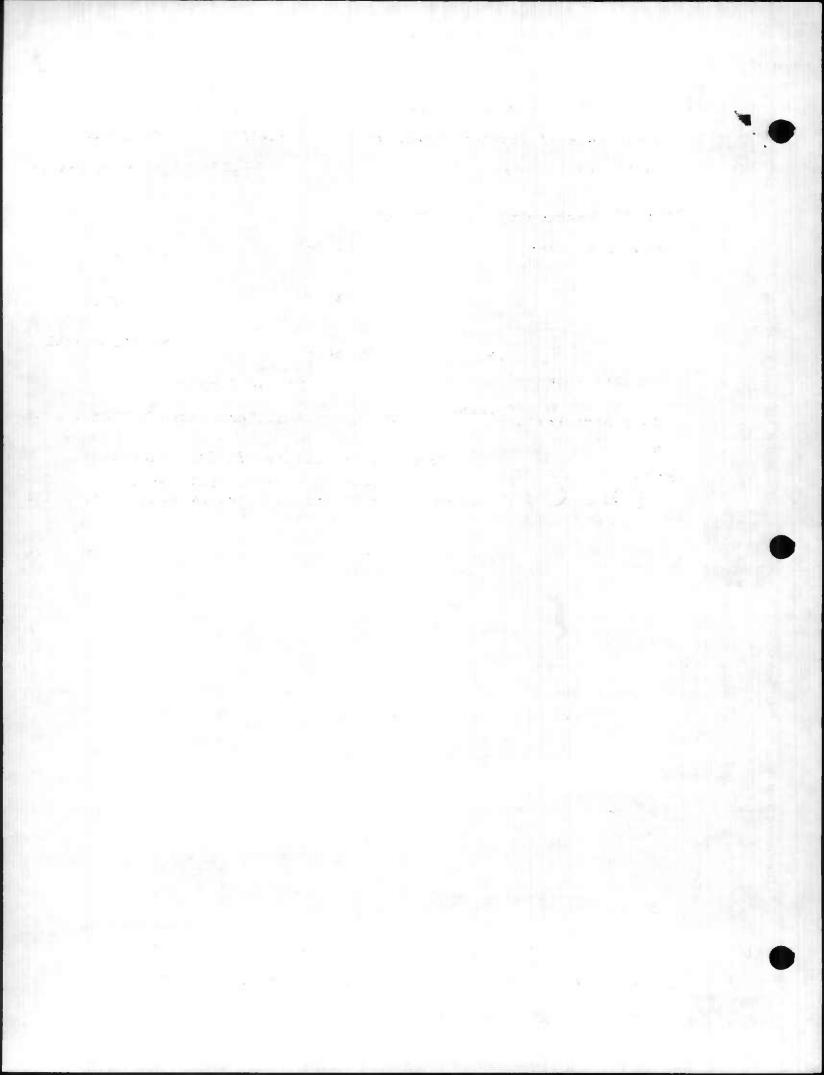
32. Registrer's Signeture

MONTROCE

6121

POCKVILLE

MD 20852



State of Maryland / Department of Health and Mental Hygiene

/	Department of Healt	n and wei	Ilc
	Certificate of Dea	th	

1 Decedent's Name (First, Middle, Last)

Physician /Medical Examiner 3. Time of Death 1450 PM

10d. Inside City Limits

White

Approximete Interval Between Onset end Deeth

1 ☐ Yes 2 ☑ No

4c. County of Death

Reg. No.

2. Date of Death

Funeral Director

the Maryland with death

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

parmit. Peges 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural; or ite any injury or other traumatic event, the Modical Examina Baltimore, Maryland 21215-0020

Physician /Medical Examiner

certificata be exec

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

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strending physicien end for use as the buriel-trans 88 signed by the signed to be detached for by Completed page 2 has certificata director, Be To slus funerel Certification: After 24 hours efter death.

Funersi Director: A filled in by

Day Month ROYCE E. PAYNE MARCH 5, 1998 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death HURLOCK DORCHESTER PALMERS MILL ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 05/05/26 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Hours 1 € M 2 □ F 222-16-4823 71 Yrs. Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Directo Rhodesdale Dorchester MD 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? United States 21659 6222 Fooks Mill Road Funerai 12. Was Decadant Evar in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specity Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, atc 1 Myes 2 No It Yes, Give Yaar or Dates: 145 - 147 f Nevar Married 2 Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Truck Farming Agriculture 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Mildred Brown Dawson Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn P. Pritchett/sister 6220 Fooks Mill Rd., Rhodesdale, MD 21659 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/98 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory Cambridge, MD 21. Signature of Funeral Service Licanses 22. Nama and Addrass of Facility Framptom-Hawkins-Eskow Funeral PO Box 43, Federalsburg, MD 21 Gs XIS AW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes

24a. Wes en autopsy

24b. Were autopsy findings svallable prior to complation of cause of death?

26. Place of Death (Check only one)

Yes 2 No

25. Was case referred to medical examiner? XXYas 2□ No

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 ☐ Homicide

29a. Certile

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28e.

Other: $_{4\square}$ Nursing Home $_{5\square}$ Residence $_{6}$ Mather (Specify)AT SCENE 28c. Injury at Work? 1 Yes

26d. Describe how injury occurre Rural Route Number,

Date of Injury
(Nonth Day Year)

B. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the course(s) and merinion as a second Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner stated.

const) 29b. Sig

29c. License number O.C.M.E

29d. Date signed (Month, Dey, Year) MARCH 6, 1998

ted cause of deeth (Item 23a) (Type, Print) and eddress of person who co Locke, MD Kon

111 Penn Street, Baltimore, Maryland 21201

State Registrar

completely

within 2 \$

Medical

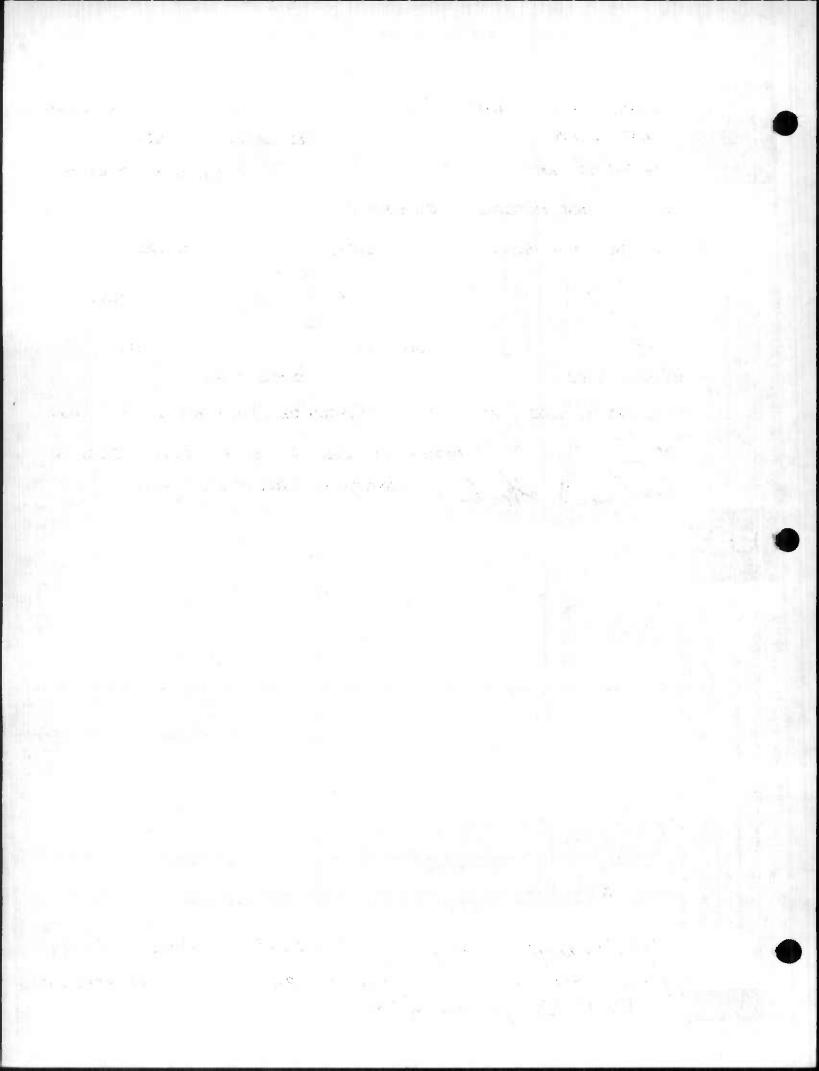
31. Date filed (Month, Day, Year) MAR 09 '98 32. Registrar's Signature " Davidson-Randell

1-5-11-01 James J. James V. J. J. J. J.

State of Maryland / Department of Health and Mental Hygiene 98 10157

							Cei	tificate c	of Death			Reg. No.		10101
П	Physic	ion	1. Decedent's Name							1	2. Dete of De		Year	3. Time of Death
J	Physic /Medi		CHARLES W. KODE, DR.						/	MARCH		998	2:45 PM	
ų	Exami	ner	4a. Facility Name (If	not institution, gi	ve street and number	")					ation of Deat			
ŀ	Funeral Director		5. Social Security No. 213-30-	ımber 6.		ge (In yrs. la:	st birthday) Yrs.	if Under 1 Ye Months Day	ar If Under	PTMOI 24 Hrs. (Min.	B. Date of Bir (Month, De	y, Year)	9. Birthp	place (State or Foreign stry)
			Usual Residenca of	Decedent							1/10/	1933	LIGHT	CIDAND
	a Marylan Sa-f show	Director	MD MD	ANNE	ARUNDEL	10c. City,	Town or Lo	cation JRNIE					1	0d. Inside City Limits 1 ☐ Yes 2 No
	oth with the 23a or 24 ust be no		10e. Street and Nun		DRIVE			10f. Zip Code 21060				U.S.A.		itry?
020	72 hours efter deeth with the Maryland neturel, or items 23s or 28s-f show deet Examiner must be notified at	by Funeral	11. Marital Stetus 1 ☐ Never Marrie 3 ☐ Widowed		12. Was Decedent Armed Forces 1 Wes 2 If Yes, Give Year or Dates:	? No	l t	Vas Decadent of Yes, specify C ☐ Yes 2 X N	uban, Mexican	gin? (Spec , Puerto Ri	ify Yes or No ican, etc.)	Bla	ce - Americ ck, White, y: WH]	etc.
Ind 2121	72 hours "natural",	eted	(Speci	15. Decedent's E			16e. Deced	ent's Usual Occ	cupation	pation during most of working			usiness/inc	Justry
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aryk	d 2 should b th and Menta 7 Is marked traumatic e	L _O	19a. Informant's Na		Type, Print)		19b. Mailin	o Address (Stre				er, City or Town	State Zin	Code
o	PSNA				DE - WIE	E	114 1	NGLEW	OOD DR	., G	LEN E	BURNIE,	MD	21060
	Pages 1 an nent of Heal nt II kem 2 rry or other				Removel from State	can	netery, crem	sition (Name of natory or other p VEN MEN		3/	Date	20c. Location -		
Ball	permit. Departm imports eny inju		21. Signature of Fur	()	11	00	RA	Name and Add	C FT	NK F	UNERA	AL HOME	2	
	_		23a Part1 Enter th	Mes disease	cications thet cause one cause on each i	d the death	· 42	6 CRAIN	HWY.,	SW.,	GLEN	BURNIE,	MD 2	1061
8	Physician		shock, or heer	failure. Lie only	one cause on eech l	ine.	DO HOT BINE	i the mode of c	lying, such as	cardiac or	respiretory e	ilest,		Approximete Interval Between Onset and Death
/Medica			Immediete Cause (F			D.		0	. /	+	2001		1	Lucak
П	Examiner		resulting in death)		е	Due to (or a	is a consequ	uence of):	your	in	<i>y</i>			iwer
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	na daeth tha atter	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1.						23b. Did tobacco use contributa to the cause of death?					
P.0	± 50										1)	Yes 2□ No	3 Prob	ebly 4 Unknown
ds,	8 5 8	d by	-											
Vital Records,	aw 1s b	Completed									24a. Was perfo	an autopsy med?	cor	pre eutopsy findings allable prior to appletion of cause death?
<u>~</u>	Tha ata h peg	Con									101	res 2 No	1□	Yes 2□ No
Vita	Physician: The this cartificata rai director, peg	Be	25. Was case referre		Hospital:					of Death (Check only o	ne)		
of	this ai di	5	1 ☐ Yes 2 N N 27. Manger of Death	0	Hospitel: 1 Inpation 28a. Date of Inju		VOutpatient	3LI DOA				denca 6 □Oth)
O	Aftar funa	ton	1 Natural 2 Accident	5 Pending Investigation	(Month, Da	y Year)	Bb. Time of Injury	28c. In W	ork? ☐ Yes 2 ☐ N	_	d. Describe r	now injury occur	rea	
Division	or Attending aftar daath. Director: Aftar d in by tha funa	Certification:	3 Suicide	6 Could not be determined	e 28e. Place of inj	ury - At home c. (Specify)	e, farm, stre				f. Location (S City or Tox	Street and Numb	er or Rura	Route Number,
Ö	ttal or A													
	To the Hospital or Attend within 24 hours aftar daati To the Funeral Director: complataly filled in by tha	edicai	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the best niner: On the basis o end manner st	r exa <i>m</i> inetior	odge, death n end/or inve	occurred at the estigation, in my	time, date and opinion, death	place, end h occurred	d due to the d at the time,	cause(s) and ma date and placa,	anner as sta and due to	ated. the cause(s)
	To tro	Σ	29b. Signature end ti	tle of certifier	4			29c. Lice	nse nu <i>m</i> ber	,		29d. Date signe		
			P RA	Uxar	rder	MD		D	500	16		March	~ 8	11998
			30. Name and address				3e) (Type, P	nnt)				0		1 1998 ore 21202
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	Sta Registr		31. Dete filed (Month	R 13 199	32. Hegistr	er's Signatur Davidson	-Randa	00						

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State of Maryland / Department of Health and Mental Hygiene 98

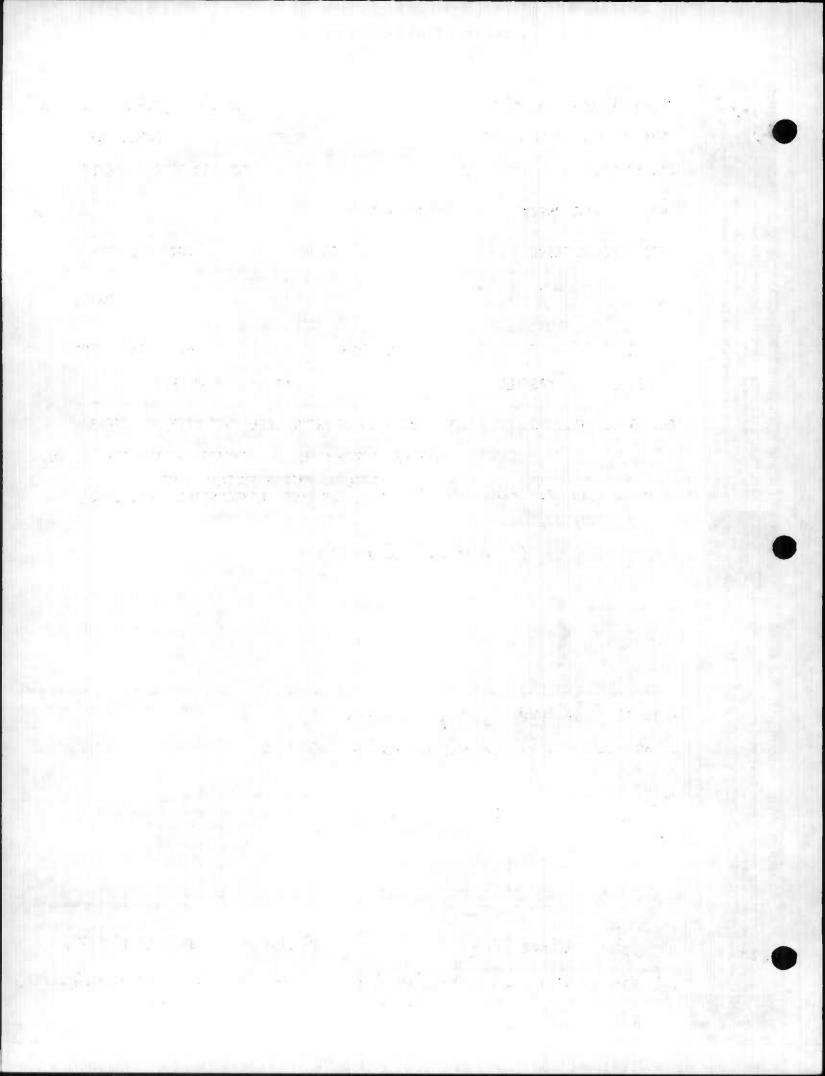
rtment of Health and Mental Hygiene 98 10158

		Certificate of Death	Reg. No.	10100							
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Day Ye	3. Time of Death							
/Medical	Mary Ellen Rabbitt	4b. City, Town, or L	Warch 16, 1998 Location of Death 4c. County of D	23:45							
Examiner	4a Fecility Neme (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL	OLNEY	MONTGO								
Funeral Director	214 12 9403 1DM 2ØF 84	r. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Birthplaca (State or Foreign IARYLAND							
the Maryland 28a-f show notified at		city, Town or Location ILVER SPRING		10d. inside City Limits 1 ☐ Yes 2 ☑ No							
offer death with the Maryland retrem 23s or 28s-f show there must be notified at Funeral Director	10e. Street and Number 3201 LUDHAM DRIVE	10f. Zip Code 20906	10g. Citizen of What UNITED ST	STATES							
etter etter	11. Meritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Wes Decedent Ever in the Armed Forces? 1 □ Yes 2 ☑ No H Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispenic Origin? (S) If Yes, specify Cuban, Mexican, Puerto		American Indian, White, etc. WHITE							
within 72 ene. than nar	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) O Coilege (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) CLERICAL	king 16b. Kind of Busine MACHINIST								
d 2 should be filed the and Mentel Hygis T is marked other traumatic event, I	17. Fether's Neme (First, Middle, Last) ARTHUR D. CASHELL	ne (First, Middle, Meiden Sumeme) E BARNSLEY									
	19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru									
1 end 2 Heelth em 27 i	ROBERT B. WILLIAMS, PERS.REP.	Place of Disposition (Name of	Date 20c. Location - City								
00	100 Buriel C Commention C C Brandwilliam Comm	ATE OF HEAVEN CEM.	3/20/98 SILVER S	PRING, MD.							
permit. Peges 1 and 2 permit. Peges 1 and 2 important: if frem 27 is any injury or other trau	21. Signeture of Funeral Service Licensee Burker P. O. BOX 5038, LAYTONSVILLE, MD. 20882										
Physician /Medical Examiner		cial Infarction (or es e consequence of):	4	Interval Between Onset and Deeth							
deeth certificate be executed e attending physician end of for use es the bunel-transit sician/Medical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	(or as a consequence of):									
d by the deteche	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the contribution of the contrib										
ne law requires the law requirements th	Citherosakrota Peripheral	Vascular Disease	24a. Wes an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?							
ician: The certificate h rector, page	25 W		1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No							
	25. Was case referred to medical examiner? 1 — Yes 2 No Hospital: 1 Inpatient 2 I	Other:	ath <i>(Check only one)</i> Home 5 Pesidence 6 Other ((Specify)							
	27. Manner of Deeth 1. Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of Injury At Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred								
tal or Attending P is after death. al Director: After tiled in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, street, fectory, office lify)	28f. Location (Street and Number of City or Town, State)	or Rural Route Number,							
To the Heapital or Attending Ph within 24 hours after deciding Ph To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7		nowledge, deeth occurred at the time, dete and place nation and/or investigation, in my opinion, death occu									
To the sound of the state of th	29b. Signature and little of certifier Access MD	29c. License number 3526	29d. Date signed (A March 1	Month, Day, Year)							
	30. Name and address of person who completed cause of death (Ite	om 23a) (Type, Print) Mathemal Drive #210 S	lver Spring Mar	eyland 20906							

DHMH 16 Rev 6/95

Registrar

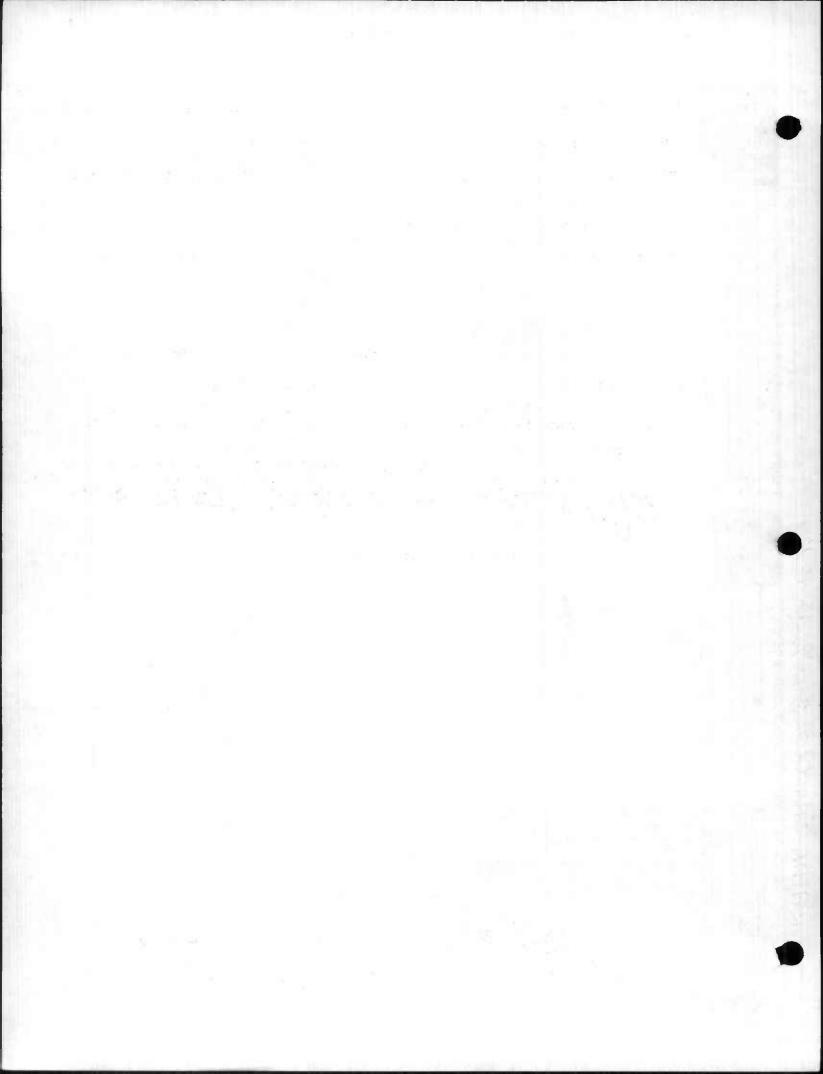
MAR 18 1998



				State of M	arylar		rtment of	Health and I		giene 9 {	10	159
			1. Decedant's Nama (First, Middla, I	ast)					2. Data of De	ath	3.	Tima of Death
	Physic		Sandra Weston Ra	hn					Month	Day 10, 1998	Year	2:45 PM
	/Medi Examir		4a. Facility Nama (If not institution, g	iva street and number)			4b. City, Town, or I				2.4J IM
	Examin	ilei	Suburban Hospit					Bethesd			gomery	
-	Funerai	_			ga (In yrs.	. last birthday)	If Undar 1 Yas	ar If Undar 24 Hrs.	8. Data of Birt (Month, Da		0	(State or Foreign
V.	Director		331-36-0382 Usual Rasidanca of Decedant	1□M 2፟፟X F	54	Yrs.	Months Day	Hours Min.	Sept.	y, Year) 20,1943	Oklaho	(Stata or Foreign
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28a-f show ont, the Medical Examinet must be notined at	6	10a. Stata 10b. County			ity, Town or Loc	cation					nsida City Limits ☐ Yas 2月 No
	the A	Director	Maryland Montgom 10e. Street and Number	ery	Ве	thesda	10f. Zip Code			10g. Citizan of \		
	with with	Ö	4517 Maple Avenu	0			20814			United		
	72 hours after death w "neturel", or items 23a	Funerai	11. Marital Status	12. Was Decedant	Evar in L	J.S. 13. V			necify Yas or No		e - Amarican In	idian.
_	ther d	E	1 Navar Married 2 Married	Armed Forcas	?	tf	Yas, specify Cu	f Hispanic Origin? (S uban, Mexican, Puart	o Rican, atc.)	Bla	ck, Whita, atc.	Great,
020	a ST.	þ	3 ☐ Widowed 4 ☑ Divorced	If Yas, Giva Yaar or Dates:		1	☐ Yas 2🔯 N	o Specify:		Specify		
21215-0020	2 hou	8	15. Decedent's	Education		16a. Deced	ent's Usuel Occ	upation		16b. Kind ot B	White usiness/industr	
215	nin 7	pie	(Specify only highast g Elementery/Secondary (0-12)	rada com <i>platad)</i> College (1-4or	F.\	(Giva I lifa. D	kind of work don O NOT usa rati	na during most of wor red)	king			
21,	d withi	E	Elementery/Secondary (0-12)	4	D+)	Home	maker			Own Ho	ome	
	e filed other vent,	Be Completed	17. Fathar's Nama (First, Middla, Las	st)				18. Mothar's Nan	na (First, Middle,	Meiden Suman	na)	
Maryland	ked be	To B	Kermit Welton					Carolyn	Weston			
ary a	shous M M	-	19a. Intormant's Name/Ralationship	(Type, Print) Daug	hter	19b. Mailin	g Addrass (Stre	et and Number or Ru	ral Routa Numbi	er, City or Town,	Steta, Zip Cod	a)
	nd 2		Victoria Elizabe	_								
e,	Hear Hear ofthe		20a. Mathod of Disposition	on Baccy i	20b. I	Place of Dispos	ition (Nama of	/ace) March	Date OO	20c. Location -	City or Town,	Stata
on On	age ant of t: M t		1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec					1				
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, once.		21. Signature of Funaral Sarvice Lie		Mo	ntgomer	y Crema	torium, I	nc.	Bethesda	Mary.	Land
Byrn eg	Depa Impo any ir		* XXXm/	1 to	MO	0689 Av	thesda- renue. B	Chevy Cha	se, Inc. Marvland	7557 1 20814-	Wiscons -3552	sin
-			23a. Part1. Ester the didense, or one shook, or hear failure. List onl	mplications that causa y ona causa on aach I	d tha daa ina.	th. Do not ante	r tha moda ot d	ying, such as cardiac	or respiretory e	rest,	Inta	roximete rval Batween
8	Physician		400								Ons	sat and Daath
	/Medicai Examiner		Immediata Causa (Finel disaasa or condition	Metas	tati	c Breas	t Cance	r			18 т	nonths
54:	Examino		rasulting In daath)		Dua to (or as a consequ	uence ot):					
7	p #	ine		b								
26	ete be executed hysician end the buriel-trensit	Examiner	Sequentially list conditions,		Dua to (or as a consequ	ienca ot):			**		
3760,	oe ex		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C								
87 cd	hysk the t	dicai	that initiated avents rasulting In daath) Last	0.	Dua to (d	or as a consequ	ance ot):					
0 89	deeth certificet e attending phy ed for use as th	Mec	S POSSESSION CHILD									
10- Box	th ce tend	an		d								
1 -	0 0 0	Physician/Med	Part II. Other algnificant conditions	contributing to death b	ut not ras	sulting in tha un	derlying causa	givan In Part I.	23b. Dld	obacco use co	ntribute to the	cause of death?
Wo	a 2 =	Phy							1 🗆	Yee 2½ No	3 Probably	4 Unknown
Ś	gned be d	by										
And Ra	w requires that been signed is should be det								24a. Was	en autopsy rmed?		utopsy tindings le prior to
SANDA A of Vital Reco	aw re is be 2 sh	Completed							, , , , , , , , , , , , , , , , , , , ,		comple of death	tion of causa
A &	stclan: The law i certificate has b lirector, page 2 st	E							10.	ras 2⊠No	1 □ Yas	s 2 No
12 Ital	in: Infica tor, p	Be C	25. Was casa retarred to madical					26. Pleca of Das				
Z >	Physician: r this certific rral director,	To B	axaminar? 1 ☐ Yas 2 █ No	Hospital: 1 ☑ Inpati	ant 2	ER/Outpatient	3 DOA	Whar	oma 5 Rask		er (Specify)	
00		n: T	27. Mannar of Death	28a. Data of Inju	iry	28b. Tima of	28c. In			now injury occur		
O	th. : After e funer	tio	1 □Naturai 5 □ Pending 2 □ Accidant invastigati	(Month, Da	y Year)	Injury		onk? □Yas 2 □ No				
JN, Division	or Attending effer deeth. Director: Afte I in by the fune	fice	3 ☐ Suicida 6 ☐ Could not	d Zoa. Placa of in	ury - At h	oma, farm, stra	at, tactory, offic	0	28t. Location (S	Streat and Numb	ber or Rural Rou	ıta Number,
AHN	offer of the plan of the blan	Certification:	4 ☐ Homicida	building, al	c. (Spaci	fy)			City or Tov	vn, Stata)		
0	Hospital		29a. Cartifiar 1 Certifying P	hyalcian: To tha bast	ot my kno	owledge, deeth	occurred at the	tima, data and place	and due to the	cause(s) and me	ennar as stated	
~	P Fur	edicai		minar: On the basis of and manner st	t axamina	ation and/or inv	estigation, In my	opinion, daath occu	rred at tha tima,	data and placa,	and dua to tha	cause(s)
X	To the Hospital or Attent within 24 hours efter deet To the Funeral Director: completely filled in by the	Me	29b. Signatura and titla of certifiar	MA_	1		29c. Lica	nsa number		29d. Data signe	d (Month, Day.	Year)
	F 5 F 8	1	1//	1/Le			D220	186		March 10		
	V		20 Name and did a									
			30. Nama and addrass of person who	complated causa of	leath (Iter	m 23a) (Type, F	rint)	54011	NESI	ZKIV	HUE	-, DC

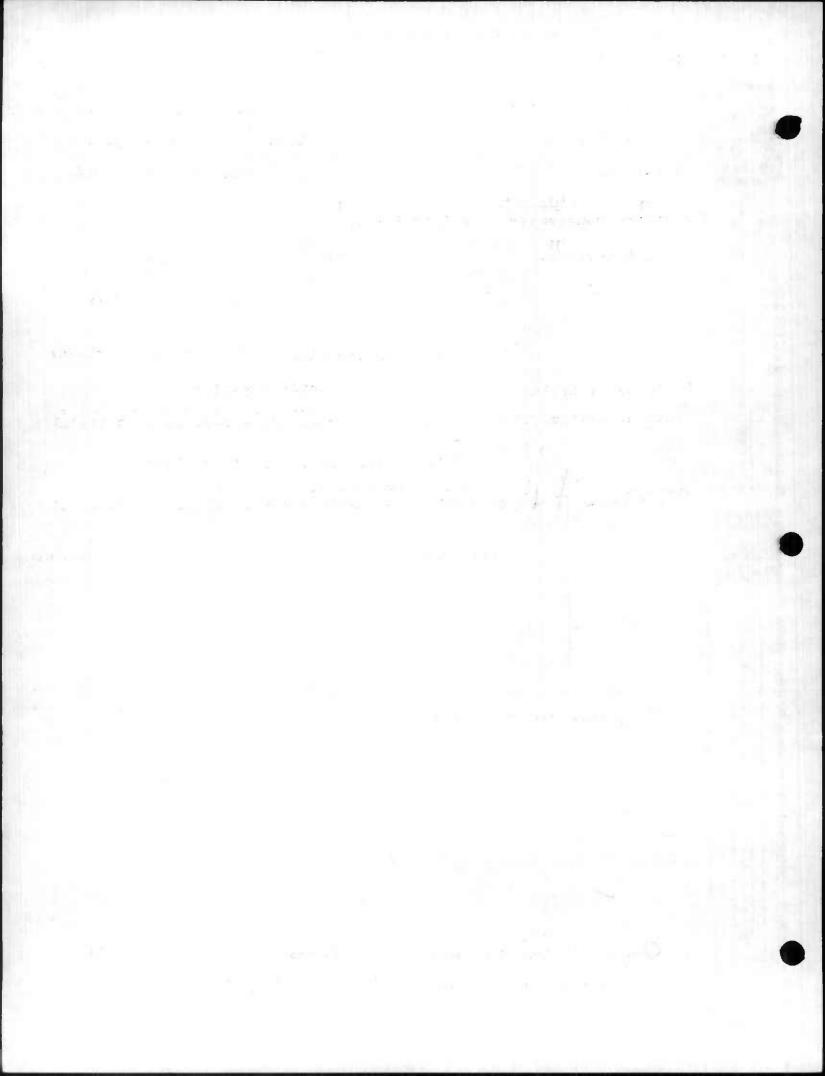
State Registrar 31. Data filed (Month, Day, Year) MAR 16 1998 32 Ragistrar's Signatura

DHMH 16 Rev 6/95



	Item#10 Ite	ър m#1	erInf 2/9/99 G768 EW Oa 10b 10c 10e 10f 19b	State of Marylar perInf G767 1/4/					giene 9 8	10	160	
	Physic	an	1. Decedent's Name (First, Middle, La Hyman L.	est)	7.			2. Date of Dea Month	Dey Y	reer lee	me of Death	
ě.	/Medi Examir		4a. Fecility Name (If not institution, give	re street and number)		4b.	City, Town, or Lo	March ecation of Deeth	9 199 4c. County of		116pm	
	Funerai Director	,-	578-48-4959		: lest birthday) If U Yrs. Mon	nder 1 Year 1	thesda f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey Jan · 1	Year) 9	omery 9. Birthplece (St Country) Maryla	tate o <i>r Foreig</i> n	
	72 hours effer death with the Marylend natural; or ffems 23s or 28s-f show occurrent from the notified at	Director	Usuel Residence of Decedent 10a. State Fla. 10b. County Pa Maryland Monts 10e. Street and Number 300 Vil	archol cit	ity, Town or Location 1 ver Spr	Zip Code		1	0g. Citizen of Wh	X	de City Limits Yes 2 ☐ No	
d 2121	72 hours efter death with "natural", or Items 23a or ad cal Examinet must be	Funeral	11. Marital Status 1 Never Merried 2 Married	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give	-20910 ecedent of Hisp	ocedent of Hispanic Origin? (Specify Yes or specify Cuban, Mexicen, Puerto Rican, etc.)			Americen india White, etc. White			
	C .	Completed by	3 Widowed 4 Divorced 15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12)		life. DO NO	f work done dur T use retired)	ing most of worki	ing	Specify: 16b. Kind of Bush U.S. G	ness/Industry		
	tel Hyg d other	Be	17. Father's Neme (First, Middle, Last,)	GSA Leas	18	B. Mother's Name		Maiden Sumeme)		ent	
Maryl	and 2 should be selfth end Mentel 27 is marked or traumatic eve	To	Louis Mayer Ras 19a. Informant's Name/Relationship (Pearl M. Raskin	Type, Print)	19b. Mailing Add	ross (Stead on	arah Ma Wumberor <i>Rum</i> Killage Gr	J Davida Mumba	r, City or Town, St	ete, Zip Code) m Spring	s FLA	
Baltimore,	permit. Pages 1 end 3 Department of Heelth Important: If item 27 (any Injury or other tr. 9000.		20a. Method of Disposition 1 Buriai 2 Cremation 3 C 4 Donation 5 Other (Specific	Removal from State 290. I	Plece of Disposition cemetery, crematory	(Neme of or other place)		Date	20c. Location - Ci	ity or Town, Star		
Balti	permit. Departming on the portal any Injury		21. Signeture of Funeral San No.		22. Nam Ives	e end Address of -Pears	of Fecility Son Fun	eral H	lome			
	Physician /Medicai Examiner		23a Pert1. Enter the disease, or com shock, or hear failure. List only mediate Ceuse Final dis resulting in deeth)	a. Preum	ith. Do not enter the	mode of dying,	such as cerdiac o	or respiratory err	ngton,	Approx Interva Onset	ZOI kimale il Between end Death	
	be executed sician and buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury	b. Due to (or as a consequence	of):						
Box 68760,	thet the death certificete be executed ed by the ettending physician and detached for use es the bunel-transit	Physician/Medical E	cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	cDue to (or as a consequence of):								
	death	sicia	Pert ii. Other algnificant conditions c	ontributing to death but not res	sulting in the underlyi	ng ceuse given	in Part i.	23b. Did to	bacco use contr	ibute to the car	usa of death?	
Is, P.O.	es thet the igned by th be detache	by	Congestive	Heart Failu	re	1 U Y	es 2□No 3	AProbably	4 Unknown			
Records,	e law requires ti has been signe ge 2 should be o	Completed						24a. Was a perfori		24b. Were auto available p completion of death?	prior to	
	iclan: The is certificate ha rector, pege	Be Co	25. Was case referred to medical			2	6. Place of Death	1 Ye		1 ☐ Yes	2□ No	
Division of Vital	this el di	은	examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Dey Year)	28b. Time of Injury	DOA Other: 28c. injury at Work?	4 Nursing Hor	ne 5 Reside	ence 6 Other			
Divis	al or Attendi s efter death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Specif	reet and Number n, Stete)	or Rural Route	Number,					
	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edicai	29e. Certifier 1 ☐ Certifying Ph (Check only one)	yaician: To the best of my kno ninar: On the basis of exemina end manner stated.	owledge, death occur alion and/or investige	red at the time, tion, in my opini	date end place, a on, death occurre	and due to the co	ause(s) and mann ete and plece, and	er es stated. d due to the cau	JSO(S)	
	To To t	Σ	29b. Signature and title of certifier			29c. License n	umber		9d. Date signed (i		ar)	
1	2		30. Name and address of person who		m 23a) (Type, Print)	50			harch 9	1998	7 m 2 m 3 m	
	Sta		31. Date filed (Month, Day, Year)	32. Registrer's Signa	600 01d 6	eorge tou	in Road	Bethes	da, mp			
	Registr	ar	MAR 16 199	gena Davids	March 82							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedant's Nama (First, Middia, Last) 2. Date of Death 3. Tima of Deeth Day 1998 Month MARCH 10, 4:25 PM ANNA MACHLIS REICH 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death BETHESDA

If Under 24 Hrs.

Alin

Alin

B. Data of Birth
(Month, Dey, Year) SUBURBAN HOSPITAL MONTGOMERY 5. Social Sacurity Number If Undar 1 Year 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 F Deys Yrs. 230-52-6509 85 OCTOBER 5, 1912 NEW YORK Usuel Residance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 NO No MARYLAND MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7808 RENOIR COURT 20854 UNITED STATES OF AMERICA 12. Was Decedant Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Detes: 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puarto Ricen, atc.) 14. Race - American Indien Black, Whita, atc. 1 □ Nevar Married 2 □ Merried 1 ☐ Yas 2 No Specify: Specify: 3 ₩idowed 4 Divorced WHITE 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usuei Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Eiamantary/Secondery (0-12) Collega (1-4or 5+) TEACHER EDUCATION 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Sumama) MOSES MACHITS FANNIE MOSCOWITZ 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) JUDITH REICH FRANK/DAUGHTER 12114 GREENLEAF AVENUE, POTOMAC, MARYLAND 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Ramovai from Stata 4 ☐ Donetion 5 ☐ Other (Specify) B'NAI ISRAEL CONCREGATION CEM. 3/11/1998 OXEN HILL, MARYLAND 21. Signatura of Funerai Service Licanses 22. Name and Addrass of Facility
EDWARD SACEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert 1. Entar tha disaasa, or complications that ceused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina. Approximate Interval Batween Onset and Death Immediata Causa (Finai MULTIPLE SYSTEM FAILURE DAYS disaase or condition rasulting in daath) Due to (or as a consequence of): GENERALIZED ARIERIOSCIEROSIS YEARS Dua to (or as e consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yss 20 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? PARKINSONISM

Physician /Medical Examiner

physician and the buriel-trans

been signed by should be detac

certificate

After

Director: /

To the Hospital of within 24 hours of To the Funeral Discompletely filled in

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Medical

Box 68760.

P.0.

Records,

Viital

Division of

Hospital or Attending Physician:

ALNO

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avent once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ŏ items 23a

should be filed within 72 hours effer and Mental Hygiene. merked other than "natural", or ite

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

the Marylend

Exami Sequentielly list conditions, if any, leeding to immadiata ceuse. Enter Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Physician/Medicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Be Completed 25. Was cesa rafarrad to medicel 1 Yas 2 No Certification: To 27. Manner of Death

Hospital: 1
☐ inpatiant 2 EP/Outpatient 3 DOA 28a. Data of injury (Month, Day Year) 28b. Time of

Piace of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

26. Place of Death (Check only ona) 1 Tes 2 No

completion of cause of death? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred 28c. Injury at Work?

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

2- No

29a. Certifier

1 Naturai

2 Accidant

4 Homicide

3 Suicida

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piace, and dua to tha causa(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to tha cause(s) and manner stated. 29c. Licanse number

29b. Signature and title of certifier

5 Panding

invastigation

6 Could not be determined

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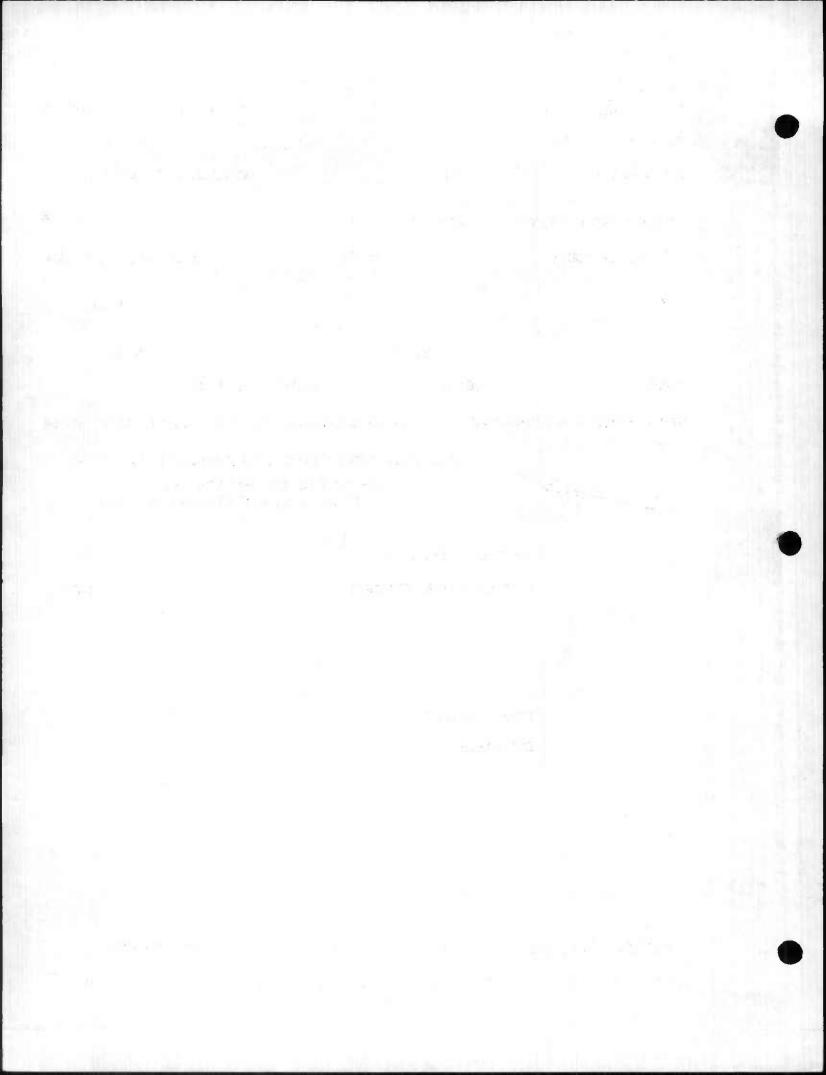
29d. Data signed (Month, Day, Year) MARCH 10, 1998

30, Nama and eddress of person who complated ceusa of death (Itam 23a) (Type, Print)

KENNER MO. 5454 Wisconsin for Chery HARRIS M 31. Data filad (Month, Day, Year)

State Registrar

22. Registrar's Signeture MAR 16 1998



h and Mental Hygiene 9

	State of Maryland / Department of Health
ASP	Items: 23 part I 27 per MED 6-758 4/15/98 Certificate of Deat

Items: 23 part I,27 per MEO G-758 4/15/98 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death Month Day Year **Physician** Richardson, Jr. Thomas MARCH 1998 2315 P James 10 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SILVER If Under 24 Hrs. HOLY CROSS HOSPITAL SPRING MONTGOMERY If Under 1 Year 6. Sex 1⊠-M 2□ F 8. Date of Birth (Month, Day, Year) July 13,1959 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Yrs. 577-90-7090 38 Washington, DC Director Usual Residence of Decedent with the Marylenk 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Magical Examinar must be notified at Yes 2 No Director N/A N/A Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5626 13th Street NW 20011 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No 14 Yes, Give Year or Dates: 1980-83 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. is 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Accountant Non-Profit Organization 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lona Cates James Thomas Richardson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Stephanie Rose Richardson/ wife 5626 13th Street NW Washington, DC 20011 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If he any injury or od 1 Burial 2 Cremation 3 Removal from State Quantico National Cemetery Mar. 13, 1998 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home, Inc. Signature of Funeral Service License elbeck 254 Carroll St. NW Washington, DC 20012 ese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, in. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) RIGHT VENTRICULAR DYSPLASIA Examine Due to (or es a consequence of): Examiner physician end the burlat-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 80 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 1 Yee 2 No 3 Probably 4. Unknown þ 2 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceuse of death? certificata has page 2 t⊠Yes 2 No 1 Yes 2 No director Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) XYes 2□ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3X DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After 1 X Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide

Division of Vital Records, Attending s after deeth. 6 To the Hospital within 24 hours a To the Funeral C Hospital completely

Bur

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. **Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

11,1998 MARCH O.C.M.E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

edical

31. Dete filed (Month, Day, Yeer) MAR 16

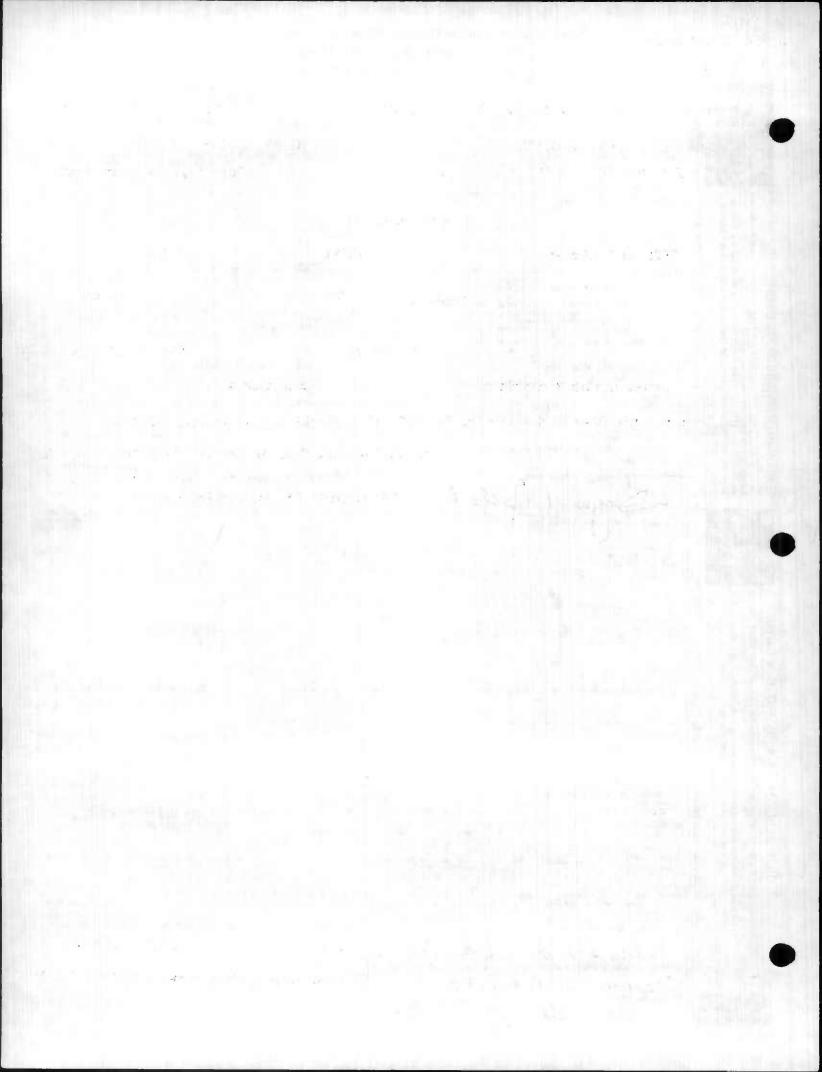
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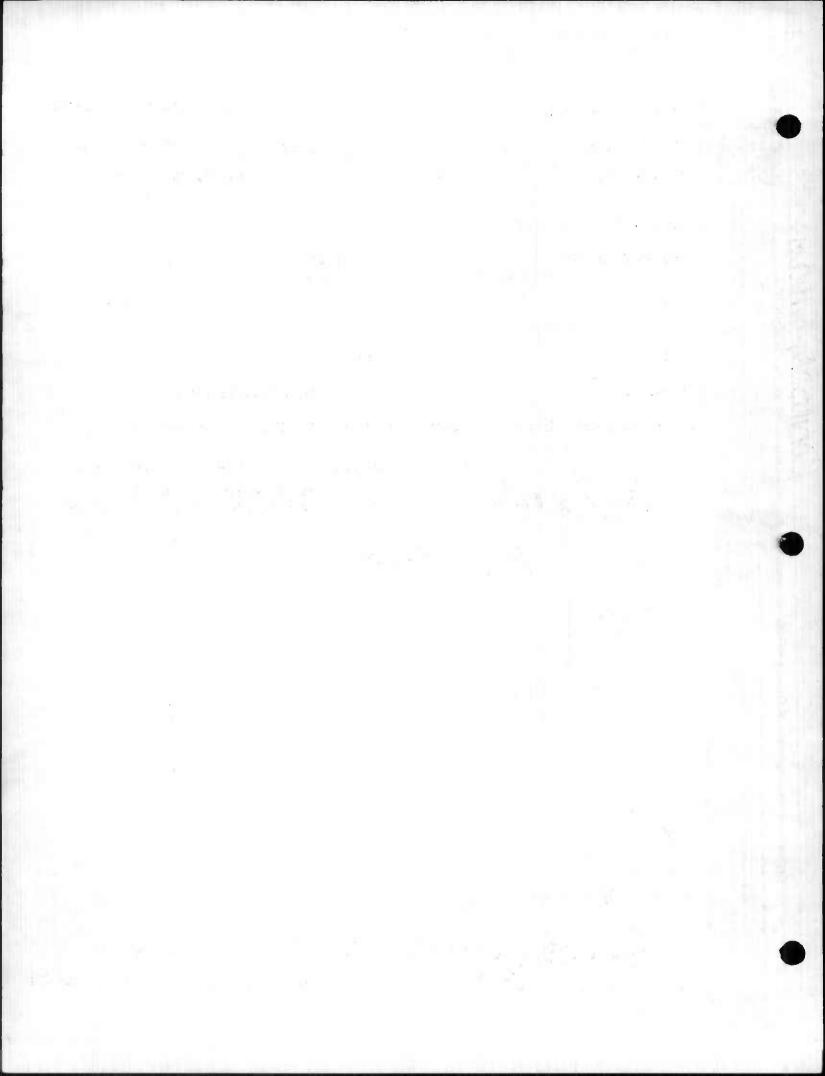
-adentz 320 Registrar's Signature
Julian Windows - Randelle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



		Decedent's Neme (First, Middle, Last	1	U	ertificate of	Dealli	2 Date - Co	Reg. No.		2 75-115
Physicia	ın						2. Dete of D Month	Dey	Yeer	3. Time of Deeth
/Medic		Lillian Mae Robi 4e. Facility Neme (If not institution, give			1	th City Town and		13,1998		4:12AM
Examine	er					4b. City, Town, or Lo	ocation of Dea	4c. Coun	ty of Deeth	
	e	Doctors Communit 5. Sociel Security Number 6. Se	y Hospital	rs. last birthd	av) If Under 1 Year	Lanham If Under 24 Hrs.	R Date of B	Princ	e Geo	rges
ineral rector		10	M 289 F	87 Yrs	Months Devs	Hours Min.	8. Dete of Bi (Month, D	ey, Year)		olece (State or Foreign ntry)
,		579-10-0064 Usuel Residence of Decedent		07			July 9	, 1910	Mary	Land
		10a. State 10b. County	10c.	City, Town or	Location				1	0d. Inside City Limits
100000000000000000000000000000000000000	tor	Maryland Prince Ge	orges F	lyattsv	vi116					1 ☐ Yes 2 🙀 No
á l	Directo	10e. Street and Number	OI BED	iyaces v	10f. Zip Code			10g. Citizen o	Whet Cour	ntry?
		4205 73rd Avenue			20.	784		U.S.A		
	Funeral	11. Maritel Stetus	12. Wes Decedent Ever in Armed Forces?	1 U,S. 1	3. Was Decedent of I-		ecify Yes or N	o- 14. Re	ece - Americ	
	ру Fu	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Dates:		1 ☐ Yes 2 ☑ No		Hican, etc.)	Spec		
	2	15. Decadent's Edu	cation	16e. De	cedent's Usuel Occup	etion		16b. Kind of	Whi Business/Ind	
١	Completed	(Specify only highest grad Elementary/Secondery (0-12)	completed) College (1-4or 5+)	(G	cedent's Usuel Occup ive kind of work done e. DO NOT use retire	during most of work d)	ing			,
	E	12	Conege (1-401 5+)	Hom	emaker			Own	Home	
	Bec	17. Fether's Neme (First, Middle, Last)		12011		18. Mother's Name	e (First, Middle			
	To	Howard Beall				Anna Est	-0110 1	ones		
		19e. Informent's Name/Reletionship (Ty	rpe, Print)	19b. M	alling Address (Street	end Number or Run	al Route Numb	ber, City or Tow	n, State, Zip	Code)
		Sandra L. Brock (d	aughter-in-1	aw) 13	109 Briard	liff Ter	ace G	ermanto	wn Ma	208/4
		20e. Method of Disposition	201	b. Piece of Dis	sposition (Name of crematory or other place		Dete	20c. Location	- City or To	wn, Stete
		1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)					116 100	D	1 1/	
		21. Signeture of Funerel Service Licens	9 1		coln Cemet 22. Name end Addre	ery 5/	10/98	Brentwo	od,Ma	ryland
		Drie & Si	alan	F	rancis J.	Collins I	uneral	Home,	Inc.	
	-	23s. Part1/Enter the durase, or compl	cetions thet caused the de	eath. Do not	00 Univers	sity Blvd.	W., Si	lver Sp	ring,	MD 20901 Approximete
n		23s. Part1 Enter the disease, or compleshock, or heart failure. Lift only or	ne ceuse on each line.		one are mode or dyn	,9, 00000	or reaphotoly t			Interval Between Onset and Deeth
al		Immediete Ceuse (Finel	1 11-	1.8						
r		diseese or condition resulting in deeth)	Actuc	As a	No				i	
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ŀ	Examiner	Sequentially list and divine). — Due to	o (or es e con:	requeres of:				1	
,	Exa	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due (c	(or es e con:	sequence or):				1	
1	edical	thet initieted events	Due to	(or es e cons	sequence of):					
- 10.0	_	resulting in deeth) Lest	544 10	(01 03 0 00113	equence or).					
	2									
1:	SICE	Pert II. Other significent conditions con	tributing to death but not	resulting in the	underlying cause oiv	en in Pert I	23b. Did	tobacco use o	ontribute to	the cause of death?
1,	Physician/M							Yae 20 No		bably 4 Unknown
	by F							-77.00		
1	8						24e. Wes	an eutopsy ormed?	24b. We	ere autopsy findings ellable prior to
	Completed						pen	OTHER!	COL	mpletion of cause death?
	E						10	Yes 2 No		☐Yes 2☐No
	Re	25. Wes case referred to medicai			·	28 Place of Death				J. 65 ZLINO
	0	exeminer?	lospitel: 1 Inpatient 2	☐ ER/Outpet	tient 3 DOA Oth	28. Plece of Deetler: 4 Nursing Ho			hor /Consil	d
		27. Manner of Deeth	28e. Date of Injury (Month, Dey Year)		of 28c. Injur			how injury occi		7)
	Certification:	1 Accident 5 ☐ Pending Investigation	(Month, Day Year,) Injur		k? Yes 2 ☐ No				
2.62		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A	t home, ferm,	street, fectory, office		28f. Location	Street and Nur	ber or Rura	I Route Number,
1	9	4 Li Homicide	building, etc. (Spe	icity)			City or To	wn, Stete)		
10.00	edical	29e. Certifier (Check only one) 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) 1 Certifier (Check only one) 1 Certifying Physical Certifier (Check only one) 1 Certifying Physical Certifier (Check only one) 1 Certifier (Check one) 1 Cer	ilclan: To the best of my k her: On the basis of exami end menner steted.	nowledge, de ination end/or	eth occurred et the tin Investigation, in my o	ne, dete end piece, pinion, death occurr	and due to the ed et the time,	ceuse(s) end n	nenner as st	eted. the cause(s)
1	Σ	29b. Signeture end title of cartifier	and manner stored.		29c. Licens	e number	T	29d. Date sign	ed (Month. i	Day, Year)
		1-1 C.	0000	1	Too	200		21.	210	Q.
	-	redu	the	\sim	Va	202) [J	212	•
		30. Name and eddress of person who so	death (II	tem 23e) (Typ	e, Print)	nue, Lr	W "	2 11111	c mi	20781
State		31, Dete filed (Month, Day Year)	Registrar's Sig	mature-	14.1 HOL	ince, ci	11 ILLU	TIME	2 111	0 20101

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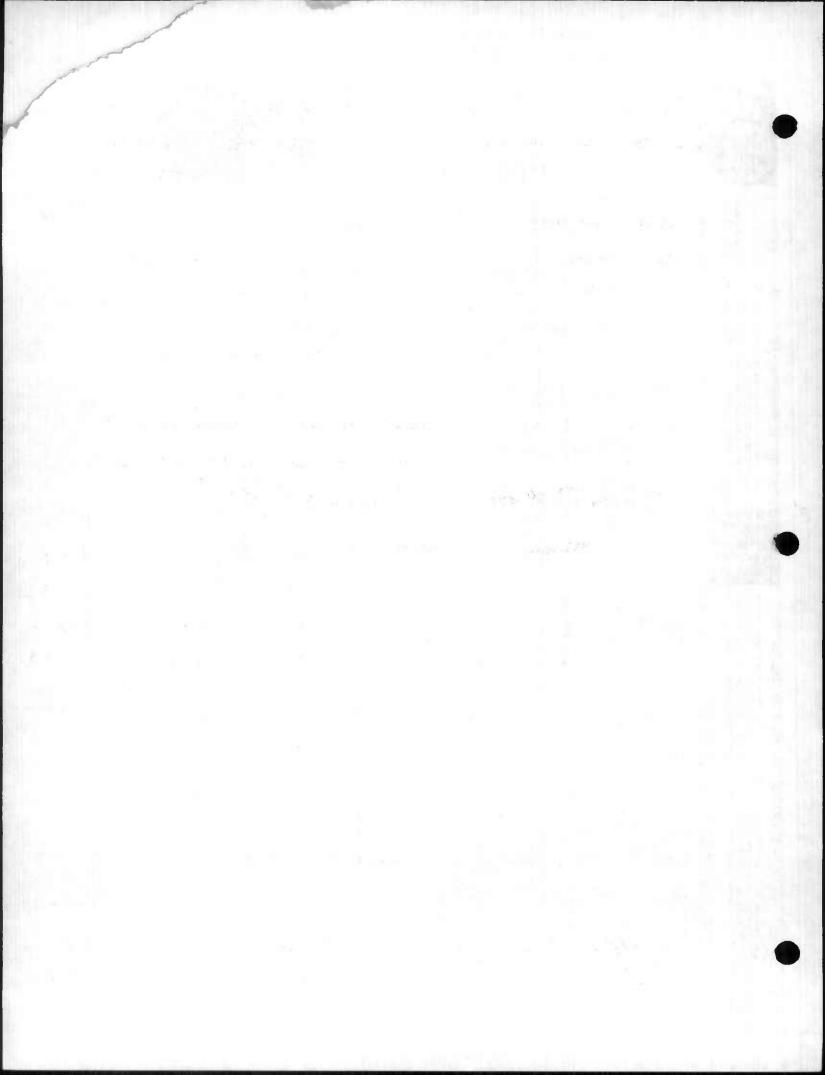


State of Maryland / Department of Health and Mental Hygiene 0

						Certificate	of Death	a wortarri	Reg. No.	19104
	Physic /Medi		1. Decedent's Neme (First, Middle) Howard		FRANCI	s A		2. Dete of D Month	Day 14 16 19	Yaer J. 03 pn
}	Exami	ner	4a. Facility Name (If not institution Washington Adv	entist Hospi	tal		Takom	or Location of Dee a Park	Montgo	omery
	Funeral Director		5. Social Security Number 072-26-6800 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last bin	hday) If Under 1 Months Months		Vin. (Month, D		Birthplace (State or Foreign Country) New York
	Maryland 1 ahow	lor	10a. State 10b. County Maryland Montg		10c. City, Town	or Location	1			10d. Inside City Limits 1 ☐ Yas 252 No
	n 72 hours effer death with the Maryland "natural", or Items 23a or 28a-f ahow added Examiner must be notified at	Funeral Director	10e. Street and Number 9624 Kanfer Cou	1rt 12. Was Decedent Armed Forces'	Ever in U.S.	10f, Zip C 2088	ode	7 (Specify Yes or Nuerto Rican, etc.)	10g. Citizen of W United S o- 14. Rece	
-0050	tural', or land	by	1 ☐ Never Married 2 ☒ Mai 3 ☐ Widowed 4 ☐ Divorced	H Vac Give	Vietnam	1 ☐ Yes 2 ☐	No Specify:		Specify:	White
d 21215-0020	filed within Hygiena. ther than	e Completed	(Specify only highe Elementery/Secondary (0-12) 17. Fether's Nama (First, Middle,	College (1-4or	5+)	(Give kind of work life. DO NOT use	done during most of retired) 1blic Acc		Accour	nting
Maryland	and Mer a marke	To Be	Howard Francis 19a. Informent's Name/Relation		196	Meiling Address (Ferrar		
Baltimore, N	ges 1 en t of Heel If Itam 2 or other		Carol Rose 20e. Method of Disposition 1838urial 2 Cremetion 4 Donetion 5 Other (5		20b. Place of cemeter	Disposition (Neme y, cremetory or oth	of	Dete	20c. Location - C	e, MD 20886 City or Town, State
Balti	permit. Pa Depertmen Important: any Injury once.		21. Signature of Funerel Service Michael	D. Dibbon	1	22. Name and 10 East Gaither:	Addrass of Facility Deer Parl	DeVol F Drive 20877	uneral Ho	
	Physician /Medical		23a. Pen I. Enter the disease, o shock, or heart feilure. List			ot enter the mode	of dying, such as car	diac or respiretory	errest,	Approximate Interval Between Onset and Death
	Examiner	Je.	disaase or condition resulting in death)		Due to (or es a d	consequence of):		14	0.0	10/443
68760,	rificete be axecuted g physician and as the bunel-transit	ledical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	c	Due to (or as a co	onsequence of):	JTRICU ARTER	y Dise	ASE.	YEARS
Вох	leath cert attendin	Physician/N	Don't II. Other plantificant and dist				VALI		EASE	YEARS
s, P.O.	uires thet tha dealers is signed by the a	by Phys	Pert II. Other significant condition				-			ribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown
of Vital Records,	s law requ	Completed	PULM	AL FAIL	INSU	FFici	ENCY	perf	s en autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica exeminer?	Hospital:				Death (Check only		1 ☐ Yes 2 ☐ No
ion of	ding Phys h. After this funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accidant investi	28e. Date of Inju (Month, De igation	ry 28b. T		Other: 4 Nursin	ng Home 5 ☐ Ras 28d. Describe	how Injury occurre	1-1-77
Division	무를	Certification:	3 Sulcida 6 Could determ	nined 286. Piece of in building, ef	c. (Specify)	m, straet, factory, o		City or To	iwn, Stete)	r or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	ledical	one) 2 Medical	ng Phyalcian: To the best Examiner: On the basis o and mannar st	f axamination and	Vor investigation, in	my opinion, deeth o	lece, end due to the occurred et the time	, date and place, er	nd due to the cause(s)
	シャノ	2	29b. Signature and falls of certify August		40.		lcense number			(Month, Day, Year) 16,1498
			50. Name and address of person	who completed cause of o	deeth (Item 23e) (Type, Print) CIARRO	L Av.	TAKON	IA PARI	16,1498 K, MD, 20912
	Sta Registr		31. Dete filed Wanth Day, Year MAR 20 1	398 File	dr's Signatury	phill				

DHMH 16 Rav 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 08: 40 PM 1. Decedent's Neme (First, Middle Last) 2. Date of Deeth Month **Physiclan** PHYLLIS ROWE-JONES MARCH /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) if Under 24 Hrs. 9. Birthplece (State or Foreign Country) N.C. **Funeral** Deys 1 M 20 F Months Hours 48 212-56-4603 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show "natural", or items 23s or 28s-f show MD Director P.G. LANDOVER 1 Yas 2 No 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 7711 PEBROOKE PLACE USA 20785 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines Never Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) DATA ENTRY PROCESSOR RAVEN TECH. 10TH 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be THOMAS GREEN 2 ADELE ROWE-JONES 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) LYNETTE JONES 3205 WALTERS LN, FORESTVILLE, MD. 20747 (DAUGHTER) 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Surial 2 Cremetion 3 Removel from State HARMONY MEMORIAL PARK3/21/98 LANDOVER, MD 4 Donation 5 Other (Specify) 21. Signeture of Euperei Service Licensee 22. Neme end Address of Fecility AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W., WASH, DC. 20011 23a. Part1. Enter the disees shock, or heert feilure , or complications thet caused tha daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximete Interval Between Onset end Death **Physician** HYPERTENSIVE /Medical Immediate Cause (Fin) . ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner The lew requires that the death cartificate be executed for use es the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Due to (or es e consequença of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ABUSE COCAINE Records, þ director, page 2 should be 24b. Were eutopsy findings evailable prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 2 No certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) examiner? To the Hospital or Attending Physic within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral directors. 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Menner of Deeth Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and menner es steted.

25 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner steted.

State

Registrar

Medical

29a. Certifier (Check only one)

31. Date filed (Month, Dey, Year) 18 1998

- GOLLE

29b. Signature and title of certifier

MAKIO

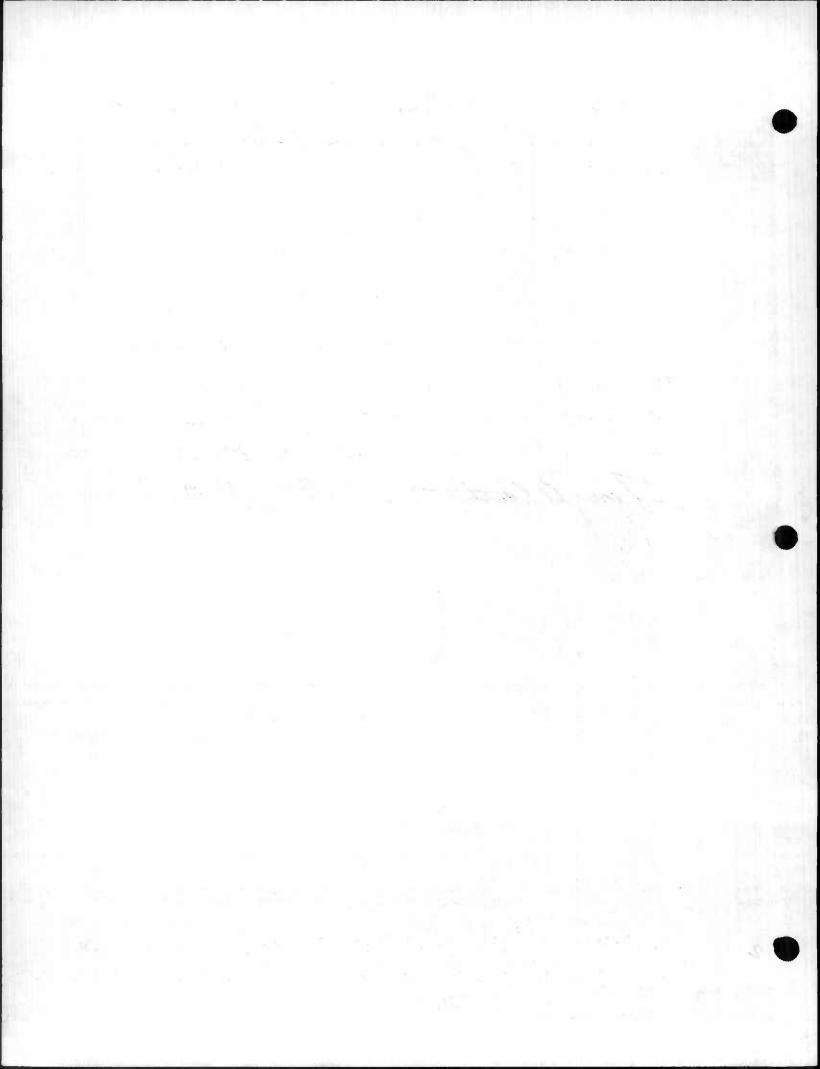


(Jem/23a) (Typa, Print)

29c. Licanse number

29d. Data signed (Month, Day, Year)

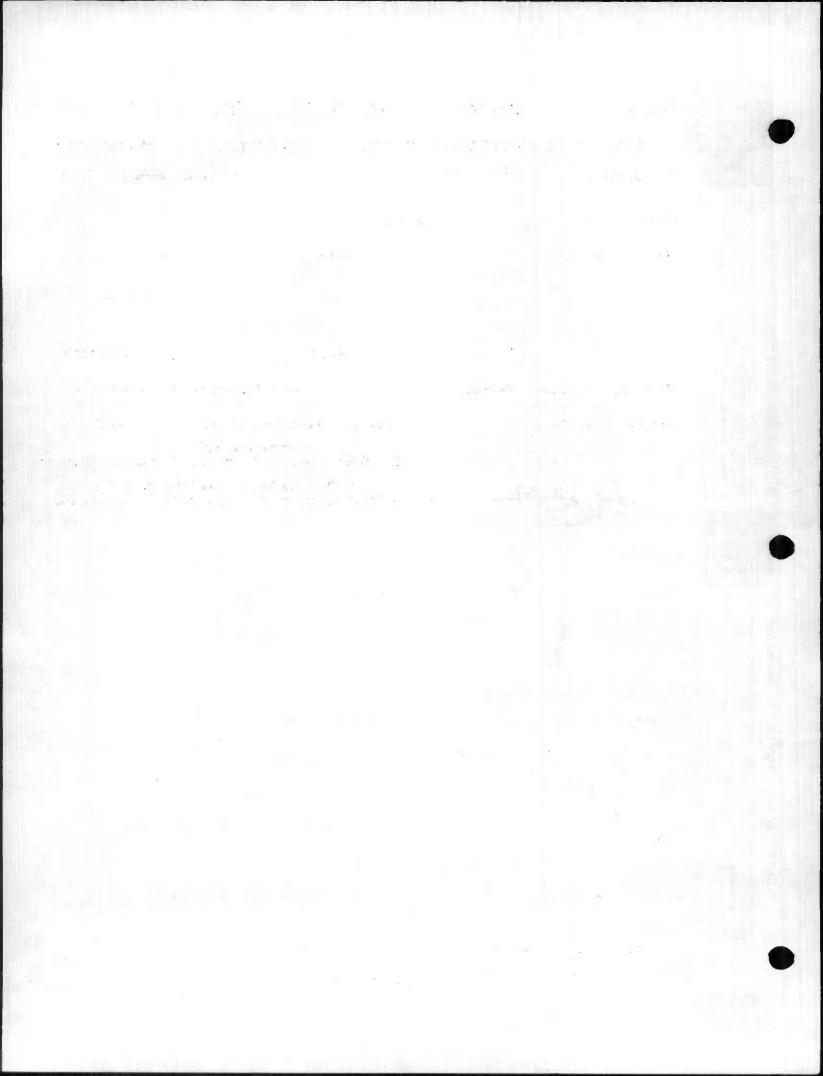
CHEVERLY, MARYLAND 2018S



State of Maryland / Department of Health and Mental Hygieneg

						Certif	icate of	Death		Reg. No.	1	1100
		1. Decedent's Nam	e (First, Middla, La	st)					2. Date of Dec	oth Day	Voor	3. Time of Death
н	Physician /Medical	Mara	aret	Edno	3	R	swe	NS	Marc	16	1998	0005 AM
4	Examiner	4a Facility Name (not institution, giv	a street and number)				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
		SHAD	Y GROVE	ADVENTI	ST HOS	SPTTA	Τ.	ROCKV	TLLE	MO	NTGO	MERV
	Funeral	5. Sociel Security N	lumber 6. S	ex 7. Ag	ge (In yrs. last l	birthday) I	Under 1 Year onths Days	If Under 24 Hrs.	8. Date of Birt (Month, Da	h		ace (State or Foreign
	Director	213-58-5	0193	□ M 2 🔀 F	86	Yrs.				22, 1911	Mary	land
	2	Usuat Residence o	f Decedent 10b. County		10c. City, To	wm or Locati	00				10	Od. Inside City Limits
	aryle arbo						OII				1	1⊠ Yes 2□ No
	vith the Ma	Maryland		ery	Rockv		Of. Zip Code			10g. Citizen of V	Mhat Caunt	2002
	THE PORT OF											
	and 2 should be filed within 72 hours after death with the Manyland ash and Mental Hyglena. 17 Is marked other than "natural", or items 23a or 28a-f ahow artraumatic avent, the Manical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status	cson Aven	12. Was Decedent	Ever in ITS	13 Wes	20850		necify Yes or No	United 14. Bac	STAT e - America	
_	P. Iter d	1 Never Marr	ied 2□ Married	Armed Forces?	,	If Ye	s, specify Cub	Hispanic Orlgin? (Sp an, Mexican, Puerto	Rican, etc.)	Blac	ck, White, e	
21215-0020	urs af			If Yes, Give Year or Dates:		10	Yes 2 ☑ No	Specify:		Specify	Whit	e
9	"natural",		15. Decedent's Ed		16	a. Decedent	's Usual Occup	pation		16b. Kind of Bu	usiness/ind	ustry
215	ed within 72 houyglena. For than "natural, the Manical Completed	(Spec	ordery (0-12)	College (1-4or	54)	(Giva kind lifa, DO	d of work dona NOT usa retire	during most of world)	king			
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	tal Hygh d other avent, the		(First, Middla, Last,					18. Mother's Nam	ne (First, Middle,	Maiden Surnam	10)	
lai	should be nd Mental marked o umatic ave	Nickolas	columb	us Burrou	ıghs			Edna Ca	therine	Elizab	eth G	ood
Maryland	2 sho and h		ame/Relationship (Type, Print)	1!	9b. Mailing A	ddress (Street	and Number or Ru	ral Route Numbe	er, City or Town,	Stata, Zip	Coda)
	diam'r.	Marion (Gaile Sno	uffer		. O . Box		Cobb Isla	ind, Mar	yland :	20625	
Baltimore,	f item or oth	20a. Method of Dis		Removei from Stete	20b. Place cama	of Disposition tary, crameto	on (Nama of ory or other pla	(ce) March	17. 1998	20c. Location -	City or Tov	wn, State
Ĕ	Page intent uny or		5 ☐ Other (Specif					dist Church		Potom	ac,	Maryland
alt	semil. Pa Separtmen mportant: any injury ance.	21. Signature of F	heral Service Licer	1686		22. N	eme end Addre	ess of Facility mphrey Fune	ral Homa	Poolari 1	lo Tno	
8	\$2 E B B	I V	+ 4	64	M01126			tgomery Ave		ille, Ma		
		23a. Part 1. Enter t	he disease, or com	plications thet cause one cause on each li	d the death. D			0			0	Approximete interval Between
	Physician	311000, 01 1100	in remote.	010 02000 011 0201 11								Onset and Death
A	/Medical	immediete Cause disease or condition	in	PIZ	10 100 1) 10	en .				T	1:10 1 1111
	Examiner	resulting in death)		a. Pho	Due to (or as	a consequer	nce of):	0.000				inday
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	death certificate be executed e attending physician and ed for use as the bunial-transit sician/Medical Examiner	Sequentially list co	nditions,		Due to for as	a consequer	ice of):					
ó,	ian a unial.	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	erlying	0								
68760,	ate b thysic the b	that initiated event: resulting in death)	5	C	Due to (or as	a consequen	ce of):					
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Box	requires that the death certive been signed by the attending should be detached for use a letted by Physiclan/M			V								
	the a the shed is	Part ti. Other signit	icant conditions o	ontributing to death b	out not resulting	In the unde	rlying cause gi	ven in Part i.	23b. Did	obacco use co	ntributs to	the cause of death?
P.0	requires that the seen signed by the chould be detached by Physe eted by Physe	1 Sun	11 6	06401	261	4	1 < f i	0.10	1)20	Yes 2 No	3 Prob	bably 4 Unknown
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0	requirement controller	6010	0 6	4011						rmed?	ava	nilable prior to inpletion of cause
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	Tha Tha Corr	Hyp	inter	vion					10,	res 2 No	1 🗆	Yes 2000
Vital	certificate has rector, page 2	25. Was case lefer examiner?	red to medical	Hospital:			Ott	26. Place of Dea				
of	Physician: this certific ral director,	1 Yes 2		Hospital:			SLI DUM		ome 5 Resid)
L C	Ing P	27. Manner of Deat	5 Pending	28a. Date of Inju (Month, Da	ly Year)	. Time of Injury	28c. Inju Wo	ryat ork?]Yes 2∐No	280. Describe	now injury occur	red	
Sic	Attending in death. ector: After by the fune iffication	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not b					1 192 5 140	28f Location /	Streat and Num!	ner or Pure	l Route Number,
Division	or Attendi after death. Director: A 1 in by the fi	4 Homicide	determined	28e. Place of In building, el	ic. (Spacify)	Terrii, Street,	tactory, office	'	City or To		707 OF 7107G	riodio ivambor,
_	pital Durs Filled	29a, Certifier	CT Carthdan Dh	veleine. To the heat	of my knowled	as death as	ourred at the ti	mo date and place	and due to the	cause(s) and m	annar ac et	ated
	To the Hospital or Attending Physician: Tha is within 24 hours after death. To the Funeral Director: After this certificate he completaly filled in by the funeral director, page Medical Certification: To Be Com	(Check only one)	2 Madical Exam	ysician: To the best niner: On the besis o and manner st	f examination	and/or invest	igation, in my	opinion, death occu	rred at the time,	date and placa,	and due to	the cause(s)
	Ithin Somple	29b. Signature and	title of certifier	wind maritime of			29c. Licen	se number		29d. Date signe	d (Month, I	Day, Year)
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	State Registrar	MAR	1 6 1998	Full Do	rar's Signature	andella						
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First Middle Last) 2. Date of Deeth 1998 **Physician** Month March 1:10 AM MARY ARVELLA ROBERTS 8 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hospital Glen Burnie Arundel Anne Arundel 7. Age (In yrs. lest birthday) If Under 1 Yeer 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Deys Hours 1□M 2√2 F 216.14.0123 73 Yrs Director MARCH 13,1924 MARYLAND Usual Residence of Decadent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show iner must be notified at MARYLAND ANNE ARUNDEL 1 ☐ Yes 2☐XNo Director GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 102 LINDEN LANE N.W. 21061 Completed by Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or item
any intury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 21 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE HOME MAKER OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumame) Be HOWARD E. GREGORY ANNA J. SAUER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM U. ROBERTS 102 LINDEN LANE N.W. GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY, INC.3-9-98 BELTSVILLE, MARYLAND 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE. S.W. GLEN BURNIE, MD. 23a Part1. Enter the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ancer lyear. **Examiner** Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit and Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760. physiclan Physician/Medical Due to (or as e consequença of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 0 23b. Did tobecco use contribute to the cause of death? ۵. Emphysema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, Completed by 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate I or Attending Physician: after death.
Director: After this certifica director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA P Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending Investigation 1 Yes 2 No To the Hospital or Attendition 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and placa, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Date filed (Month, Day, Year)
MAR 1 0 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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Sherif Elassal

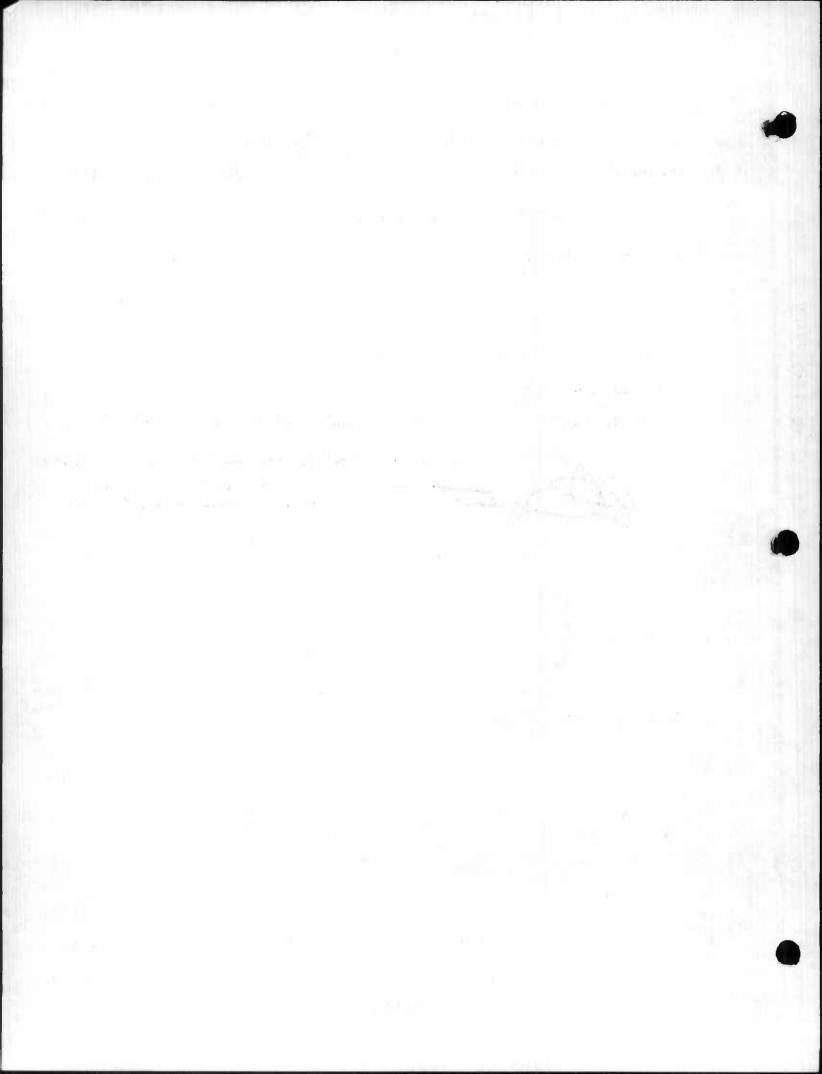
North Arandel Hospital 301 Hospital Drive Glen Burnie, MD 2/05/1

337 Registrars Signature

348 Julia Variation-Arandelle ;

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March, 8, 1998



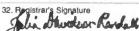
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month March 17, 1998 Year **Physician** HERBERT LEROY RICHARDS 1:25PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Civista Medical Center La Plata Charles | Months | Days | Hours | Min. | April 2, 1938 | Mary I and Mary I 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**□**XM 2□ F 219-34-8369 Yrs. 59 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes XIX No Director Maryland Charles Hughesville 10e. Street and Number 10g. Citizan of What Country? 7672 Leonardtown Road 20637 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be James Clinton Richards Margaret Virginia Adams 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Department of Health e important: If item 27 is any injury or other tra Joy Elaine Richards - Wife 7672 Leonardtown Rd., Hughesville, MD 20637 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oakland Cemetery 3-21-98 Waldorf, Maryland 5 Other (Specify) 21. Signature du unerdi Servicu Lionno Marik G. Brohawi 22. Nama and Addrass of Facility Huntt Funeral Home, Inc. M00053 Marik G. Bröhawi M00053 P. O. Box 156, Waldorf, MD 20604-0156

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one causa on each line. Approximate intarval Between **Physician** Intracerchiel Hemorrhage immediate Cause (Final 30 40 Vrs disease or condition resulting in death) = xcesiir Anticoaquiation Examiner UNENCUM Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Diseasa or injury that Initiated evants rasulting in death) Last Physician/Medical Due to (or as a consequence of): Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco uss contributs to the cause of death? Dinletos Mellitui 1 Yss 2 No 3 Probably 4 Hinknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hypertension conne Alcibil Abusa 1□ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Mariner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how Injury occurred 1- Naturai 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datamined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledga, death occurred at the time, data and piace, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and manner stated. Medical 29a. Certifian (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D48136 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Michael Greenberg, MD #2 St. Patricks Drive Suite 402 Waldorf, Maryland 20603 31. Data filed (Month, Day, Year)

State Registrar

MAR 2 9 1998



Herbert Leroy Richards Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be nothed at

Pages 1 and 2 should be filed within 7 nent of Health end Mental Hygiene. int: If item 27 is marked other than "I

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To the Funeral Director: A completely filled in by the fu

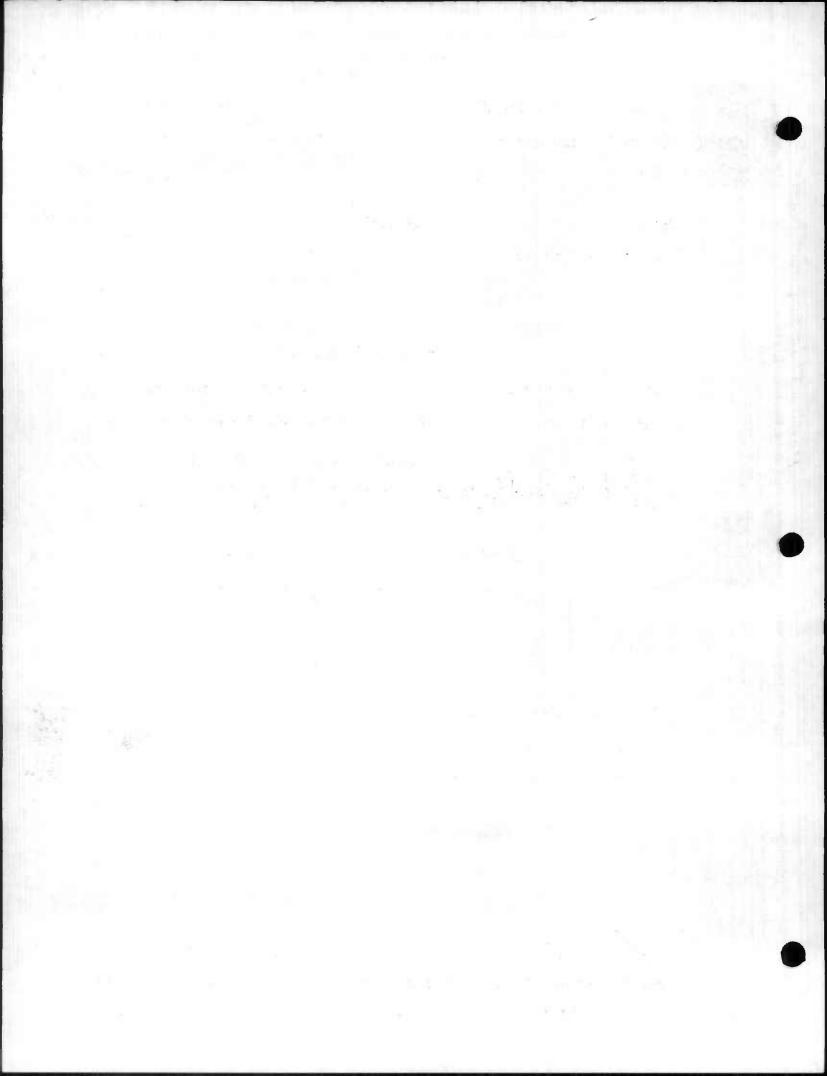
P.O. Box 68760,

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Division of Vital

Hospital or Attending Physician:

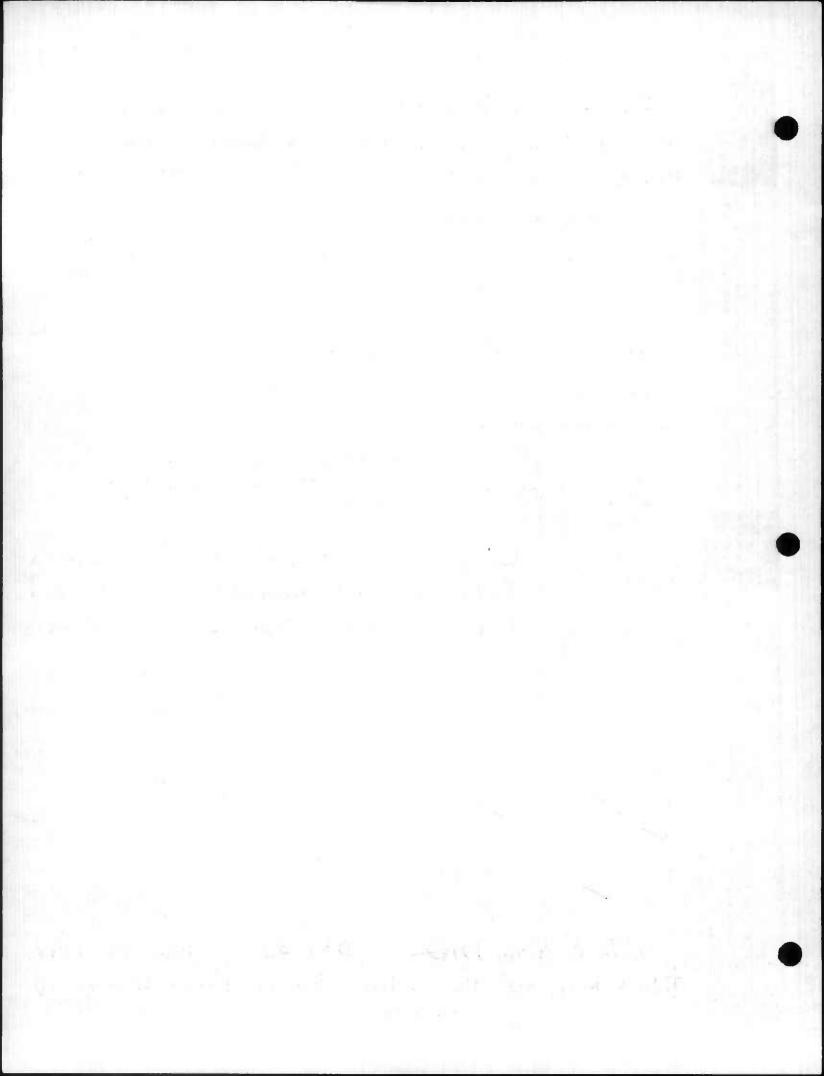
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Marie, Kedmiles H., Mar 1998 01130AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital General Columbia Howard ounty Howard Hours Min. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days 1□ M 2 4 90 **Director** 218-36-5065 Maryland Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mast be notified at 1 ☐ Yes 2X No Director Anne Arundel Severn MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 21144 937 Reece Road U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, its Medical Examinar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping Accounting 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Horan Edith Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Edith Ann Redmiles (Daughter) 937 Reece Road Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremetion 3 ☐ Removal from State Woodlawn Cemetery 3/17/98 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee PRINCE & CHAPEL (BOX 195) Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final Congestive Heart Failure disease or condition resulting in death) **Examiner** Examiner Due to (or as a consequence of): bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and attending physician for use as the buna P.O. Box 68760, Artery veurs Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss coptributs to the causa of death? sata has been signed by page 2 should be detact 1 Yss 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to-medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es steted. 29a. Certifier (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37155 nmy Mar 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 11085 Little Patuxent Rita PKWY Columbia MD 31. Date filed (Month, Day, Year) State 21044 MAR 1 8 1998 Registrar



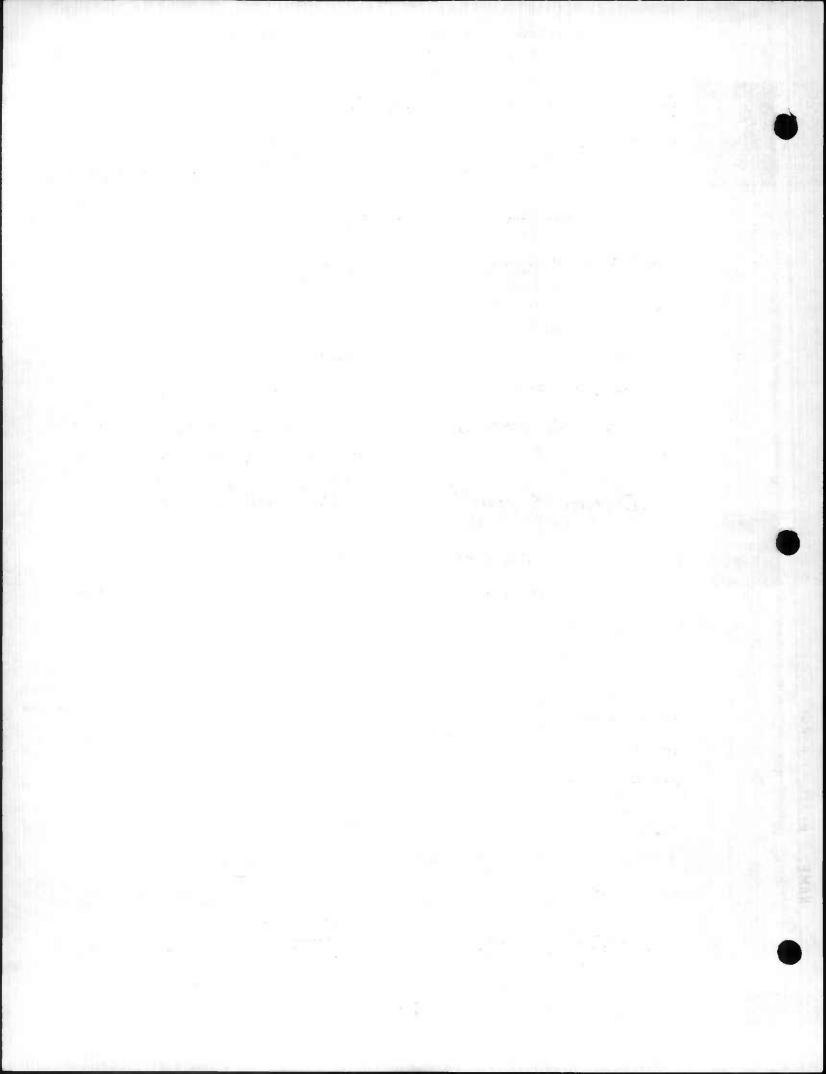
2. Date of Death

3. Time of Death

1. Decedent's Name /First Middle Last

Records, P.O. GEORGE Division of Vital READ AME:

Month CI 0 William 1998 13:55 MARCH /Medical 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Daath 4c. County of Death Examiner TZ. AGNES HEALTHCARE BALTIMORE. MD Baltimore City If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) July 21, 1918 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months ₩ 2□ F Yrs. 79 Director Pennsylvania 167-05-5201 Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? death v 719 Maiden Choice Lane U.S.A. 14. Race - American Indian, 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 2 should be filed within 72 hours after end Mental Hygiana. Is marked other than "natural", or ite Yes 2 No f Yes, Give 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 WWII 1 ☐ Yes 2 ☐XNo Specify þ Specify: White lf ₹ēs, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Cottega (1-4or 5+) 12 Vice-President Cement Plant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George W. Read Janet D. Wright 19a. Informant's Neme/Relationship (Type, Print) 19b. Malting Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health end Important: if Item 27 is m any injury or other traun Mrs. Susan Makoff (Daughter) 1758 Willow Springs Dr. Sykesville, MD 21784 20b. Placa of Disposition (Name of cametery, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 1 Data 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/20/98 Glenshaw, PA Mount Royal Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee PAIGHT FUNERAL HOME & CHAPEL (Box 195) 22 Sykesville, MD 21784 (410)-795-1400 rean Haw 23a. Part1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each he. Interval Between Onset and Death **Physician** /Medicai immadiate Cause (Final disease or condition rasulting in death) · ADENOCARCINOMA - RIGHT COUN. YEARS Examiner Due to (or as a consequence of) Examiner CHRONIC RENAL FAILURE YGARS. physician and the burial-transit Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) ettending usa the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? signed by 1 | Yes 2 | No 3 | Probably 4 | Onknown HYPERTONSION by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed peen ANEMIA has 1 Yas 2 No After this certificate 1 ☐ Yes 2 ☐ No HISTORY OF TRANSIENT ISCHEMIC ATTACK 25. Was casa refarred to medical examiner? Be 28. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 0 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident 24 hours efter death Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ 29a. Certifie 1 🗹 Cartifying Physician: To tha best of my knowladga, daath occurrad at tha time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or trivestigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. within 2 the th 29d. Date signed (Month, Day, Year) 29b. Signature and title of a 29c. Licensa number 2 P11704 mo. MARCH 15, 1998 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) AVENUE, BALTIMORE, MO, 21229. MAZEN GHAN1 , M.O. 900 CATON 31. Dete filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 8 1998 Registrar



98-1160-033 j**bm** SAMUEL R.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DDICK			C	ertificate	of of	Death		Reg. N	No.	10	1 / 1		
	1. Decedent's Name (First, Middle, La	st)					2. Dete of		No.		3. Time of Death		
Physician	Samuel Riddick						MARCI	H 01,	199	8 Year	19:05 PM		
/Medical Examiner	4e Fecility Name (If not institution, given PRINCE GEORGES					4b. City, Town Chever	n, or Location of Do	eath 4	4c. County PRIN	of Death	ORGES		
Funeral Director	5. Social Security Number 6. S	MM 2DE	yrs. last birthde Yrs.	y) If Under Months			Min. 8. Date of (Month, Feb.	Birth Dey, Yee	943	9. Birthpla Country Virgi	ce (Stete or Foreign Y) Lnia		
2 2	Usual Residence of Decedent 10e. State 10b. County	100	. City, Town or	Location						100	d. Inside City Limits		
ehor e d at	O									1.00	1 ☑ Yes 2 ☐ No		
vith the Mar or 28a-fel be notified	Maryland Prince (eorge s Ca	apitol 1	10f. Zip				10a. (Citizen of V	What Countr	v?		
ath with	603 Addison Road	_		2074	13			U.S	.A.				
d within 72 hours after death with the Manyland giene. If then "naturel", or frems 23s or 28s-1 show the Majical Examiner must be notified at Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	in U,S.	R. Was Decede If Yes, speci 1 ☐ Yes 2	fy Cub	an, Mexicen, F	n? (Specify Yes or Puerto Rican, etc.)	n Indian, lc. can-America					
n 72 hours naturel', dical Exp	15. Decedent's Ed (Specify only highest gre	ducetion de completed)	16a. Dec	edent's Usual	Occup k done	pation during most o	ost of working 16b. Kind of Business/Industry						
	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOTuse tructio				Pr	ivate	e Indu	stry		
tal Hygind of other svent, the Se Co						18. Mother's	s Name (First, Mid	First, Middle, Meiden Surneme)					
should be and Mental marked o umatic av	Calvin Riddick					Glenni	ls Marie	Port	rter				
d 2 should th and Mer 7 is marks trsumatic To	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address	(Street	and Number	or Rural Route Nu	m <i>ber, Cit</i>	y or Town,	, State, Zip C	2ode)		
25 5 5	Robin Brown - Cot	ısin	4503	Capta	in	Duval :	Drive, U	pper	Mar1	boro,	MD 20772		
T of	20a. Method of Disposition 1 ☐ Buriel 2 ☒ Cremetion 3 ☐	Removal from State		remetory or ot	her ple		Date 02 / 1 5 / 00			- City or Tow			
pemit. Pag Department Important: It any injury o	4 Donation 5 Other (Specifical Service Lices						03/15/98	AI	exano	ırıa,	Virginia		
permit. Pag Department Important: b sny injury o pnce.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 2078 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate												
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.								1	Approximate interval Between Onset end Deeth		
Physician /Medical	Immediate Cause (Finel disease or condition	· home	1- DIA	Wies									
Examiner	resulting in death)		to (or as a cons		,								
P = D	NOTE OF												
death certificate be executed a estanding physician and of for use as the bunal-transit sician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury	Due Due	to (or as a cons	equence of):						1			
entiticata be ling physicia e as the bu	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of):											
ing ing		d											
daath co	Pert II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying ca	use gi	ven in Part I.	23b. [Old tobac	CO USO CO	ontribute to 1	the cause of death?		
that the ed by the datache								☐ Yes	21 No	3 Probe	ably 4 Unknown		
been s should								Vas an au erformed		avai	re autopsy findings llable prior to apletion of cause eath?		
in: Tha law ifficata has for, page 2							1	Yes	2 No	16	Yes 2 No		
certificata rector, par	25. Was cese referred to medical					28. Place o	of Death (Check or	nly one)					
2 00 2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 KER/Outpat	ient 3 DO	A Ot	her: 4 Nurs	sing Home 5 F	Residence	6 □Oth	her (Specify)			
Attending Ph or death. ector: After th by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Yes	28b. Time Injury	of 28	Bc. Inju Wo 1 □	ry at ork?] Yes 2 No	28d. Descr	1	0		LBY UDI		
rs after death. at Director: After ted in by the funering Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc. (St	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)						end Numi	ber or Rural	Route Number,		
	29a. Certifier 1 Certifying Ph	yeician: To the best of my niner: On the basis of exar	knowledge, de	ath occurred a	it the ti	me, date and	place, end due to	the cause	(s) and m	anner as sta	ited.		
the Hosp in 24 hou the Fune aplately fil	one)	and manner stated.	interpretation of					_					
Within To the comple	29b. Signifure and title of certifier	ugue		29c.						9d. Date signed <i>(Month, Dey, Year)</i> MARCH 02, 1998			
(1)	30. Name and address of person who	completed cause of death			ree	et. Bal	timore,	Marv	land	21201			
State	31. Dete filed (Month, Dey, Year)	32 Registrar's S				-,							

DHMH 16 Rev 6/95

Registrar

MAR 1.6 199





Please	Type or Print in B State of Maryland						ble.	7.0	
	State of Marylant			Death	, ,	20) IUI	12	
1. Decedent's Name (First, Middla, La	st)				2. Date of Deat			of Death	
Jane MacDonald	Rankin				Month March 1	Day 1, 1998	Year 6:40) pm	
4a. Facility Name (If not institution, giv	a street and number)			4b. City, Town, or	Location of Deeth	4c. County			
Heartland Healt 5. Social Security Number 6. S		act hirthday) If I	Under 1 Year	Adelph:			ince George's		
579-48-4304	□ M 2D(F 72	aut on though	nths Deys				a or Foreign		
Usuel Residence of Decedent 10a. Stete 10b. County	10c. City.	Town or Location	n				10d, Inside	Clty Limits	
Manual and Dadwas								es 2 No	
Maryland Prince (10e. Street and Number	george's	Adelph:	1. Of. Zip Code		10	Og. Citizen of V	What Country?		
2113 Rolander St	reet		207	83		U.S.A.			
11. Marital Status	12. Was Decedent Ever in U.S	5. 13. Was I		Hispanic Origin? (5 ban, Mexican, Puer		14. Rac	a - American Indian,		
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				to Rican, etc.)		ck, White, etc.		
3 XWidowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:	101	es 2X No	Specify:		Specify	White		
15. Decedent's Ed (Specify only highest gra	ducation da complated)	16a. Decedent's (Giva kind	of work done	during most of wa	orking	16b. Kind of Be	usiness/Industry		
Elementary/Secondary (0-12)	College (1-4or 5+)	Iifa. DO N	OT usa retire	9d)		0 ==			
17 Faihar's Nama (First Middle 1	2	Homer	maker	10 Math - d- 41-	mo (First Milet)	Own Ho			
17. Falher's Name (First, Middle, Last)	-7.6				me (First, Middle, N		na)		
Angus D. MacDon				Etta	Pritchar				
19a. Informant's Name/Relationship (ural Routa Number,			0.0701	
Jane Rankin Reevo		1320 Kin	~	1 Street,			Maryland City or Town, State	20/21	
1 ☐ Buriel 2 ☐ Cremation 3 ☐	Removal from State	metary, cramator	y or othar pla						
4 Donetion 5 Other (Specify	12.0	ropolita			3/12/98	Alexan	dría, Vir	ginia	
21. Signature of Funeral Servica Licar	J. Sart	Fran	ncis G	ess of Facility	ons Funer	al Home	e, P.A.	701	
23a. Pert1. Enier ihe disease, or com	plications that caused the death.	Do not enter the	mode of dy	ing, such as cardie	enue, Hya	CCSVII	Approxim	0781	
shock, or heert failure. List only	one cause on each line.						Interval B Onset an		
Immediate Cause (Final disease or condition	CARDIOMYOPAT	ישי							
resulting in death)	a.	as e consequenc	e of):						
	OSTEOPOROSIS								
Sequentially list conditions,	D	as a consequenc	a of):						
if eny, leeding to immediate cause. Enter Underlying	ANOREXIA DYS	DHACTA					1		
Cause (Disease or Injury thet Initiated events resulting in death) Lest	U.	as a consequence	e of):				i		
L.							i I		
	d								
Part It. Other significant conditions of	ontributing to death but not resul	ting In the underly	ying cause g	iven in Part I.	23b. Dld to	bacco use co	ntribute to the cause	e of death?	
MALIGNANT PAIN R	FOUTRING NARCOT	TC			1 🗆 Ye	8 2 No	3 Probably 4	□Unknown	
TRIDIONANT TAIN K	EQUIRING MARCOI	. 10.							
ANALGESIA.					24a. Was ar perform	n autopsy ned?	24b. Were autops: aveliable prio	r to	
							completion of deeth?	Cause	
					1□ Ye	s 2 🛭 No	1 ☐ Yes 2	□ No	
25. Was case referred to medical examiner?					eth (Check only ons	a)			
1 ☐ Yes 2 X No		R/Outpatient 3	_ DOA		Home 5 Reside				
27. Manner of Deeth 1 XNaturel 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. inju	nyat ork?]Yes 2∐No	28d. Describe ho	w Injury occur	red		
3 Suicide 6 Could not be determined		ne, farm, street, fa	actory, office		28f. Location (Str. City or Town	reet and Numb , Stata)	er or Rural Route Nu	mber,	
(Check only 2 Medical Exam	yalclan: To the best of my know ilner: On the basis of examination	ledge, deeth occu	urred et the t	lme, date and place	e, and due to the ca	usa(s) end ma	inner as steted.	e(s)	
one)	end menner stated.								
29b. Signature and little of certifier				se number		C. GAINGIA	d (Month, Day, Year)		
Kay Will	new this		D301	11	l×	3-13	-48		

20725-0385

Division of Vital Records, P.O. Box 68760,

Physician /Medicai Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be not find at

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fater death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the innerial director, page 2 should be deteched for use as the buniel-transit

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

31. Dele filed (Month, Day, Year) MAD 16

Gary W. Jones, M.D.

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)





VAN

REAVES

State of Maryland / Department of Health and Mental Hygiene

tificate	of Death	Reg. No.

Physician
/Medical
Examiner

1 Decedent's Name (First Middle Last) VAN REAVES

2 Date of Death Month Day 3. Time of Death

4a Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL

MARCH 4b. City, Town, or Location of Death 5, 1998 4c. County of Death 2:35P.M.

Funeral Director 5. Social Security Number 579-80-0014 Usual Residence of Decedent

M 2 F 40 10c. City, Town or Location

7. Age (In yrs. last birthday)

Yrs.

Oxon Hill

CHEVERLY Hours Min. 8. Date of Birth (Month, Day, Year)

Dec • 23, 1957 If Under 1 Year Days

PRINCE GEORGES Birthplace (State or Foreign Country)

Wash.D.C. 10d. Inside City Limits

11 Yes 2 No

with the Merylend r 28a-f show deeth

r than "natural", or items 23s or the Medical Examiner must be permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Examine

Physician

/Medical Examiner

physician and the bunel-transit

USB BS

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signed to

page 2 certificate has

this funaral

After

3

noletely To the Within To the comple

after death. Director: Aft

Attending

6

Hospital 24 hours

the deeth certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

edical

Baltimore, Maryland 21215-0020

Director Funeral þ Completed

10e. Street and Number 11, Marital Status

10a State

Md.

1000

Lindsay Road 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 20 Married

Prince Georges

20748 Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10f. Zip Code

1 ☐ Yes 2 No Specify:

Months

10g. Citizen of What Country? U.S.A.

> 14 Race - American Indian Biack, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Elementery/Secondary (0-12) College (1-4or 5+) 11

Cook

17. Father's Name (First, Middle, Last)

3 Widowed 4 Divorced

Sanford

Chambers

18. Mother's Name (First, Middle, Maiden Sumeme) Mary

Reaves

Food

19a. Informant's Name/Relationship (Type, Print)

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Lindsay Rd. Oxon Hill, Md. 20748

Frances Reaves 20a. Method of Disposition

1X Buriai 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, cremetory or other place) Harmony Mem. Park 20c. Location - City or Town, State

Landover, Md.

4 Donation 5 Other (Specify) 21. Signature of Funeral Service License

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, euch es cardlac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

22. Name and Address of Facility Hunt Funeral Home 34th St.S.E.Wash.D.C.20020

3/13

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence ot).

Due to (or as a consequence of):

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given In Part I.

23b. Did tobacco usa contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes

24e. Was an autopsy

111 Penn Street, Baltimore, Maryland 21201

24b. Were autopsy tindings eveileble prior to completion of cause of death?

26. Place of Deeth (Check only one)

2□ No

Approximate Interval Between Onset and Death

25. Was case reterred to medical examiner? 1 No 2 No

27. Menner of Deeth

1 Netural

2 Accident

3 Suicide

Homicide

Hospitel: XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury

28b. Time of

28c. tnjury at Work? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe, how Injury occurred 191

Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28e.

Rural Route Num 23 81

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner existing the fause(s) Wedlcat Examination Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the fause(s) Wellcan and manner stated. 29b. Sig

5 Pending

Investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

se of death (Item 23a) (Type, Print) and address of person who completed ca

O.C.M.E.

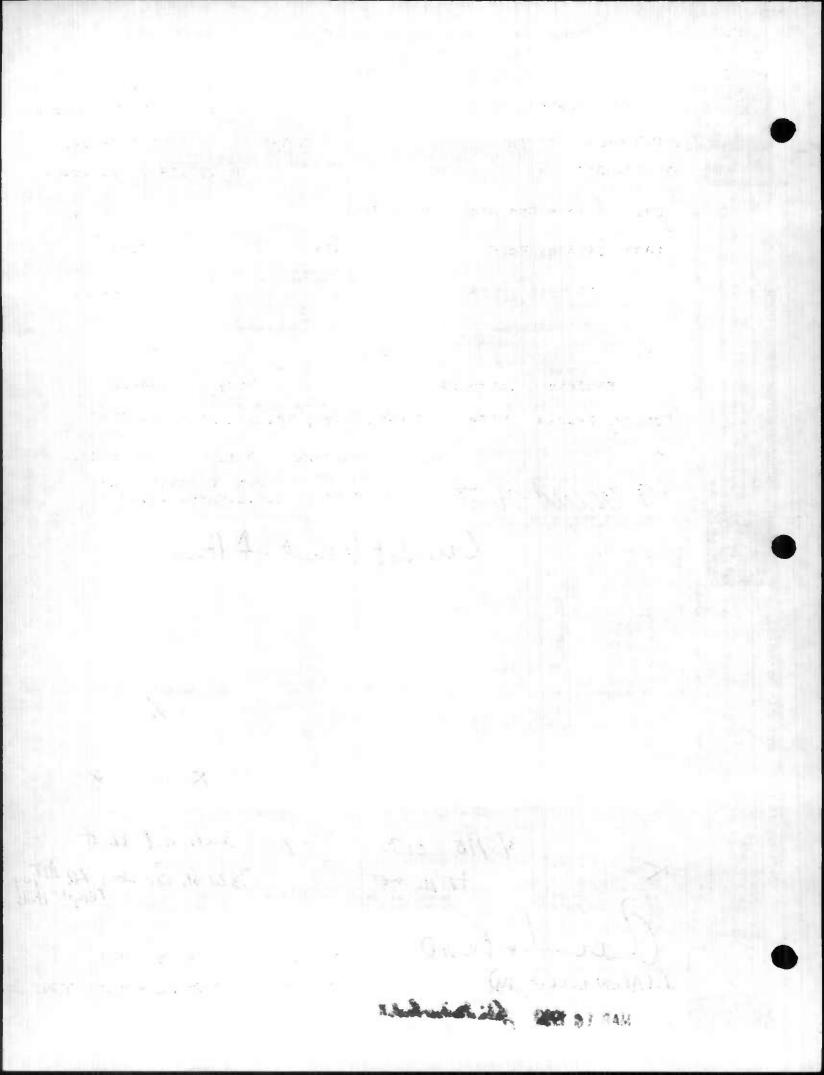
MARCH 6, 1998

State Registrar

31. Date tiled (Month, Day, Year)



DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth **Physician** Year 9L FREDERICK 5.50pm 12, 1998 MARCH /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ADVENTIST TAKOMA PARK MONTGOMERY WASHINGTON HOSPITAL 5. Sociel Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** X M 2DF Months Deys Hours 219-90-2109 Yrs. Director 32 11-4-1965 WASHINGTON, DO Usuel Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Show 7 is marked other than "naturel", or items 23a or 28a-f shov traumetic event, it a Meuical Examinat must be notived at Yes 2 No Director DC WASHINGTON 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? STREET, NW #3 U.S.A. 435 KENNEDY 20011 Funeral 11 Marital Stetus Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If them 27 is marked other transition of other traumetic and Injury or other traumetic acceptance. N/A 12th M.R. COUNSELOR 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be JOYCE REID CAR LAVAINA WILLIAM WENDELL 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 1 435 KENNEDY STREET, NW #3 WASHINGTON, DC JOYCE L. REID - MOTHER 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ■ Buriel 2 □ Cremation 3 □ Removatrom State HARMONY MEMORIAL PK 23-98 LANDOVER, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 cu Part 1. Enter the disease, or compliceties that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es a consequence of):

On Nespiratory Joiline

Due to (or es e consequenca of):

The Timmuno deficiency Syndrone Examiner Physiclan/Medical Examiner The lew requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Box 68760, for use as P.O. 1 signed by the a Part il. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by been sig Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? page 2 2 D (Vo certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Naturel 1 TYes 2 □ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Rd #220 Laurel Leo 20707 DY. GITA K. SHAH

DHMH 16 Rev 6/95

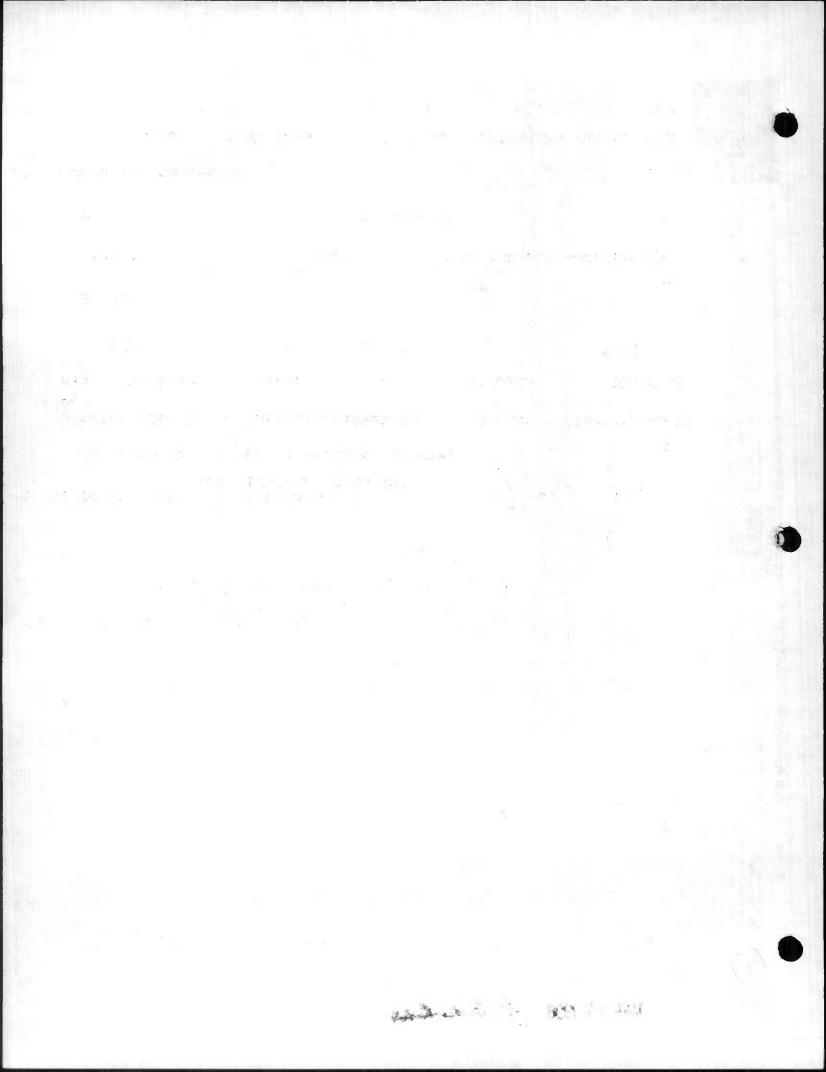
State

Registrar

31. Dete filed (Month, Day, Year)

MAR 17 1998

32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

	,					Cer	tificate c	of Death)		Reg. No.	1	011	0
	Physic /Medi		1. Decedant's Nama (First, Middla, L Marvin Bennell		П					2. Data of De Feb. 2.	eath	Yaar		of Death A.M.
	Exami		4a. Facility Nama (If not institution, g	iva street and number)			The state of	4b. City, To	own, or Lo	ocation of Deat	h 4c. Coun	ty of Death	h	
			Eastern Shore Co	rrectional	Instit	ute		1		Maryla	and So	merse	et Cour	nty
	Funeral Director		5. Social Sacurity Number 6. 238-23-1822 Usual Rasidance of Decedent	Sex 1 M 2 □ F	a (In yrs. last I 23	birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Data of Bir (Month, Di Sept.	rth 24, Year) 24, 197	9. Birti 4 Nort	hplace (State uptry) Car	or Foreign
	and *=		10a. Stata 10b. County		10c. City, To	wn or Lo	cation						10d. Inside	City Limits
	he Marylan 28a-f ahow outlad at	ector	Maryland Prince	Georges	Fort W	lashi							1 🖾 Ya	as 2 No
	23a or	Funeral Director	10e. Street and Number 515 River Bend				10f. Zip Cod	44			Unit	g. Citizen of What Country? United States		
020	be filed within 72 hours after deeth with the Maryland tial Hygliene. od other than "natural", or items 23a or 23a-f ahow event, the Modical Examiner must be notified at	by	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedant ! Armed Forces? 1 ☐ Yas 2 ☑ ! If Yas, Giva Yaar or Datas:			Vas Dacedant of Yas, specify C			ecify Yes or No Rican, atc.)	Black, Wh			
ر ک	72 h	etec	15. Dacedant's (Specify only highast of	Education	16	a. Deced	lant's Usuai Oc	cupation	st of work	ina	16b. Kind of	Business/I	Industry	
21213-0020	c • 6	Completed	Elamentary/Secondery (0-12)	College (1-4or 5	i+)	Stud	kind of work do OO NOT usa rai lent	rired)	J. 0. 110.11	9	Schoo	1		
Maryland	2 should be filed within end Mental Hygiene. is marked other than raumatic event, the Mannatic event.	To Be C	17. Fathar's Nama (First, Middla, La: Bennie F. Richa	*						a (First, Middle inderson	, Meidan Suma 1	ma)		
ary	d 2 should th end Mer 7 is marke traumatic		19a. Informant's Name/Ralationship	(Type, Print)	19	9b. Mallin	g Address (Str	eet end Numb	er or Rur	al Routa Numb	er, City or Town	n, Stata, 2	(ip Coda)	10
	12 Tag		Bertha E.A.R. He	nson	5	15 R	liver Be	end Roa	ad, F	t. Wash	nington	, MD	2074	4
baitimore,			20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Othar (Special Control of Control		cemai	tary, cram	sition (Nema of natory or other lke Cren	placa)	2	Data ./27/98	20c. Location Beltsv	-		
Balt	permit. Pages Department of Important: If I any injury or ance.		21. Signature of Funeral Sarvica Llc	ensee // and	,	Wa	Name and Ad ard Fune 1639 Ham	eral Ho	ome	e, Prin	ncess Ar	nne,	MD 21	1853
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	/Medicai	П	Immedieta Causa (Finel diseasa or condition	Recni	atory	Fail	1120					Í	37 Mi	nut 0.5
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00/00	ertificate be executed ding physician and se as the buriel-transit	Medical E	Sequantially list conditions, if any, leading to Immediate causa. Entar Undarlying Causa (Disaasa or injury that inflitated events resulting in death) Last	C	ninated Dua to (or as a									H
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j	0 0 %	Physician	Part II. Other significant conditions	contributing to death but	ut not rasulting	In tha un	nderlying ceuse	givan In Part	I.	23b. Dld	tobacco uee c	ontribute	to the cause	of death
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ol Vital necord	aw requir is been s 2 should	Completed								24a. Was perfe	en autopsy ormed?	8	Were eutopsy aveileble prior completion of of death?	r to
	0 - 2	Con								10	Yas 2 No	1	l □ Yas 2Ì	No No
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1016	ding h. After fune	Certification:	27. Mannar of Death 1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant Invastigati		Year) 28b	. Tima of Injury		njuryat Vork? □Yas 2□		28d. Dascribe	how Injury occu	irred	at	2.0.1
DIVISION		Certific	3 ☐ Suicide 6 ☐ Could not datamine									i <i>ber</i> or A u	iral Routa Nu	m <i>ber</i> ,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

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Physic	ion	1. Decedent's Name (First, Middle	le, Last)					2. Date of De Month	ath Day	17.5	3. Time of Death
/Med		Festus G.	Reynolds	, Sr.				3		998	04:30A
Exami		4a. Facility Name (If not institution	n, give street and number	r)			4b. City, Town, or	Location of Deat	4c. County	of Death	
		Washington A	Adventist	Hospi	tal		Takoma	Park	Monto	ogome	ry
Funeral	Г	5. Social Security Number		ige (In yrs. las		Under 1 Yaar onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th V Year)	9. Birthplec	a (State or Foreign
Director		578-20-5310	XIXM 2□ F	73	Yrs.	July Days	Tiodis Iviii.	10 2			ington D
death with the Menyland me 23a or 28e-f ehow		Usual Residence of Decedent 10a. State 10b. County		-	Town or Location					10d	. Inside City Limits
s 1 and 2 should be filed within 72 hours efter death with the Merylar f Heelth end Mental Hygiene. It will the marked other than "neturel", or items 23a or 28e-f show other traumetic event, the Medical Exeminer must be notified at	Funeral Director			Wash	ington	, DC					1 Yes 2 No
or 26	Dire	10e. Streef and Number			11	Of. Zip Code			10g. Citizen of V	What Country	?
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of Heelth of Hee		20a. Method of Disposition	moras, or.	20b. Plac	ca of Disposition	(Name of		Date Date	20c. Location -		
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rtme rtant		4 Donation 5 Other (S		RIV			atory 3	/ 15/98	Rivero	lare,	Ma.
permit. Pages Department of Important: If II eny Injury or o		21. Signature of Fundad Survice	Licensee			me and Addre					
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Physiclan		23a. Part1. Enter the disaase, of shock, or heart failure. List								In O	pproximete terval Between nset and Death
/Medicai Examiner	п	Immediate Cause (Final disease or condition resulting in deeth)	a Cerebru	OVASC	ULAR	THR	om Bose	5			2 mants
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that the de ed by the deteched	P.							1 🗆	Yes 2□ No	3 Probet	oly 4 Unknown
signed d be del	1 by									Odb Wass	
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Attending in death.	cati	2 ☐ Accident Investi	gation		A	1 1 1	Yes 2 No				
I or Attending to efter death. Director: After d in by the funer	Certification:	3 Suicide 6 Could 4 Homlolde determ	ined 286, Placa of II	njury - At home etc. (Specify)	e, farm, street, f	actory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural R	oute Number,
raise ed ii											
To the Hospital within 24 hours e To the Funeral Completely filled	edical	Check only 21/1 Medical	g Phyaician: To the besi Examiner: On the basis	t of my knowle	edge, deeth occ	urred at the tig	me, date and place	, and due to the	cause(s) end ma	anner as state	ed. e cause(s)
To the Hospital or Attending Phy within 24 hours either death. To the Funeral Director: After thi completely filled in by the funeral	Med	Grey	and manner s	tated.		_					
5 4 5 P	2	29b. Signatura and title of coulding	V 1//	,		29c. Licens			29d. Date algne		
(30. Name and address of person PENNIS J.	Han	el M		De	04899		5/	9/98	
(10)		30. Name and address of person	who completed cause of	death (Item 2	3a) (Type, Print)			,		20 781
()		PENNIS J.	HAND UND	42	03 10	WEEN.	sbury	Rd. 1	HY ATTI	VILL	= hip
St	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatur	•						
		A 77 (THE PERSON	400 ml	W H . HI						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1998 March 14 9:00 PM Gladys Μ. Ropka /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince Georges Cheverly Prince Georges Hospital If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 200 Yrs. 73 **Director** 579-20-2807 DEC. 21,1924 Wash. D.C. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner numbe notified at MD Hyattsville Prince Georges tXXYes 2□No Director 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? with 20784 7747 Emerson Rd. U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or items 23a any injury or other traumatic event. the Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 3 No Specify: Specify: þ White ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own_ Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Caroline V. Baker Robert G. Garner 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) 7747 Emerson Rd. Hyattsville, MD 20784 Karl J. Ropka 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4 Donetion 5 ☐ Other (Specify) 3/16/98 Alexandria, VA Metropolitan Crematory Juneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Lanham, 20706 MD Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting In death) Coma 12 hours **Examiner** Due to (or as a consequence of): Examiner 24 hours Sepsis physician and the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lesf Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 24 hours Urinary tract infection Physician/Medical Due to (or as a consequence of) 83 usa signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yas 2 No 3 Probably 4 Unknown Congestive Heart Failure þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Coronary Artery Disease certificate has be lirector, page 2 s 1 Yes 2 No Diabetes long stending Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 ☐ Yes 2 No this funaral 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident after death the Funeral Director of Illed in by the 6 Could not be determined 3 ☐ SuicIde 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, sfreet, factory, offica building, etc. (Specify) 4 T Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical ompletely (Check only one) ithin 2 o the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

March 15, 1998

State Registrar

31. Date filed (Month, Day, Year)

MAR 18 1998

33. Registror's Signature

death (Item 23a) (Type, Print)

Lanham, MD 20706

9470 Annapolis Rd.

tress of person who comp

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Hema P.

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WRC 98-1415-033 DAVID ALLEN

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q 8 10170

RICE						Cer	tificate	of L	Death		Reg. No.)	0110	
Physic	ian		me (First, Middle, Las ALLEN RIC							2. Dete of De		98 _{ear}	3. Time of Death 1:15 PM	
- /Medi			(If not institution, give		ımher)			1	lb. City, Town, or					
Exami	ner		DUNTAIN LA					HEIGHT			ORGE'S			
Funeral Director		5. Social Security 2 13-86-82	Number 6. S		7. Age (In yrs. 27	last birthday) Yrs.	If Under 1 \ Months D	raar Days	If Undar 24 Hrs. 8. Data of Hours Min.				lace (State or Foreign	
9		Usuel Residenca												
ehow		10e. Stete	10b. County			ty, Town or Lo						10	0d. Inside City Limits	
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th with th	ai Director	6702 MOU	^{umber} ıntain Lak	e Place	е		10f. Zip Co			10g. Citizen of Whet Country? USA				
ier dee	Funeral	11. Marital Status		12. Wes Dec	cedent Ever in U	J,S. 13. V	Vas Decedent of Hispenic Origin? (Specifi Yes, specify Cuben, Mexican, Puerto Ric			pecify Yas or No	- 14. Ra	ce - Americ		
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2121 3 within jiene. r then "r	mo	Elementary/Sec	condery (0-12)		(1-4or 5+)	Demo	lition	ı W	orker		Const	ructio	on	
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C T N L		Gloria F	Reed/ Moth	er		6825	Riverd	dal	e Rd.C-1	, River	dale, M	2073	37	
Baltimore, permit. Peges 1 an Department of Heal Important: If item 2 any Injury or other once.		20e, Method of Di	sposition	sition (Name netory or othe	of r plec	ce)	Date	20c. Location						
		The state of the s										sville	e, MD	
		11	Funerel Servica Licar	171.	mio	-	Name end A	T	Vann Fun	eral Ho	me, Inc	. 4804	4 Ga. Ave.	
Physician /Medical Examiner	16	Immediate Ceuse disease or condit resulting In deeth	ion	e.	han	or es e conseq	ju-8	or dylin	ot wa	S or respiretory e	ffest,		Approximete triterval Between Onset and Deeth	
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or the state of th	M	29b. Signature a	d title of certifier)		29c. L		e number	I	29d. Dete sign	ed (Month,		

Registrar

pleted cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** March 18, 1998 1:20 pm Sanders Pauline Sabina /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Silver Spring Montgomery Care Matrix 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 9. Birthplaca (State or Foreign Country) 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sax **Funeral** Days Months Hours 1□ M 2□ F 83 232-01-7693 Director 1914 | West Virginia Usual Rasidance of Decedant 10b. County 10a. Stata MD 10c City Town or Location 10d. inside City Limits Montgomery Takoma Park 1 ∰ Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6703 Prince George Ave. 20912 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∰ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after c. Department of Heelih and Mental Hygiene. Important: If them 27 is marked other than "natural", or harmy injury or other traumate. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 16a. Dacedant's Usuai Occupation 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Food and Beverage 9 Cafeteria Worker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Bernardino Mastradone Carmalla Sanducci 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Ralationship (Type, Print) Larry Sanders (Son) P.O. Box 4732 Silver Spring, MD 20914 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Removal from Stata 4 □ Donation 5 □ Othar (Specify) 3-23-98 Silver SPring, MD Gate of Heaven Cemetery 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical tmmediata Causa (Final disaasa or condition rasulting in daath) Cardiac Arrhymmia Minutes Examiner Dua to (or as a consequence of): Examiner Dementia 3-Years + Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Physician/Medicai Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Anemia 1 Yes 3 No þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed Hyperprolactinoma complation of ceuse of death? 1 Yas 2/1 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to medicel axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 # Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 DNatural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 3 Sulcida 6 Could not be datarminad 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of fnjury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar edical 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certific D17423 3-18-1998 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Deborah Goldberg M.D. 8700 Georgia Ave. Silver Spring, MD Suite 400 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

MAR 20 1998

Adia Davidson

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Baltimore, Maryland 21215-0020

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Division of Vital Records. P.O. Box 68760.

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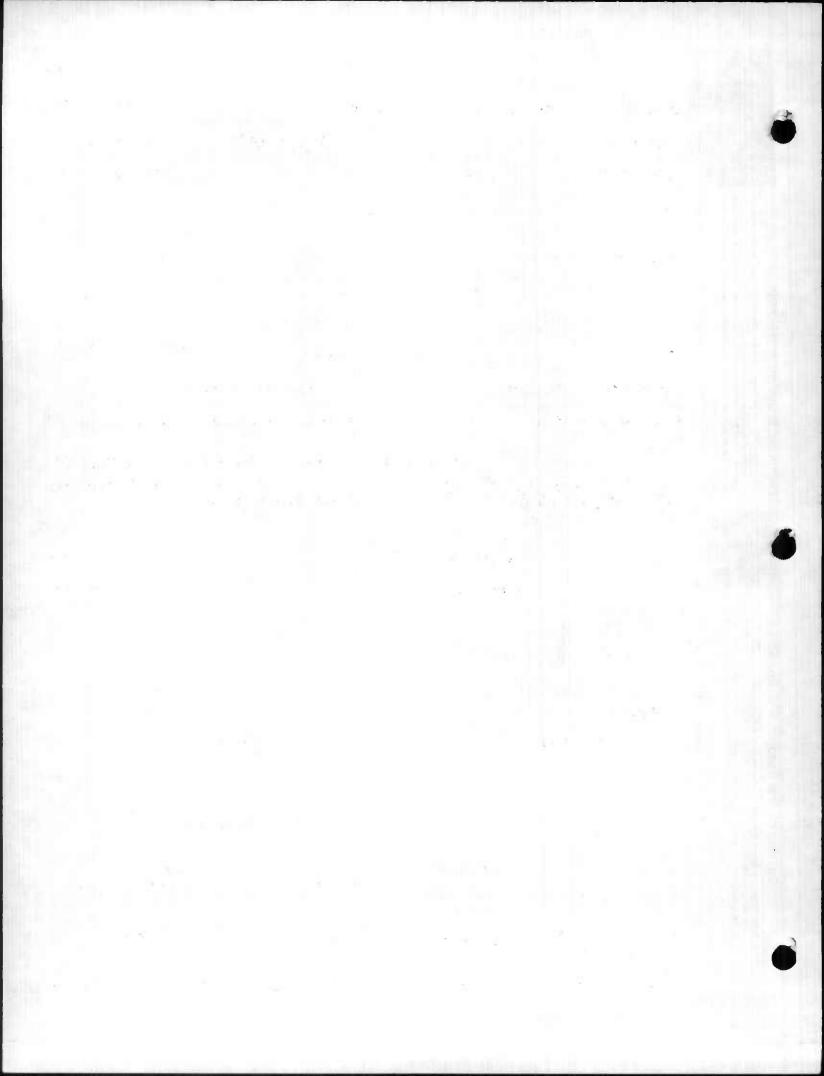
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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month Alice R. Scheidt March 17, 1998 6:15 PM /Medicai 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9827 Singleton Drive Bethesda Montgomery Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 18, 1932 If Under 1 Year 5. Social Security Number 9. Birthplaca (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 1□ M 22 F Days 150-24-4634 65 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9827 Singleton Drive 20817 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be E. Paul Robbins Sadie Rochkovsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Leon E. Scheidt/Husband 9827 Singleton Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from State March 21, 1998 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery Farmingdale, NJ 21. Signatu Funeral Service Licensee

Robert A. Pumphrey Funeral Home/
7557 Wisconsin Avenue
Bethesda, Maryland 20814=3501
shock, or heart feilure. List only one cause on each line. Bethesda-Chevy Chase, Inc. Approximete interval Between Onset and Death Immediate Cause (Finel Colon Cancer 2 Years disease or condition resulting in death) Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2K No 3 Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to Completed 24e. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only ona) Hospitei: Other: 4 ☐ Nursing Home 5 🖾 Residenca 6 ☐ Other (Specify) 2 1 Yes 2⊠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28b Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. Medical 2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Data signed (Month, Dey, Year) D04766 March 18, 1998 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

10400 Connecticut Avenue, Kensington, Maryland

20895

State Registrar

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryles Department of Heelih and Mental Hygiene. I moortant: If teem 27 is merked other than "natural; or items 23s or 28s-1 show any injury or other traumatic event, its fractical Examiner must be norther as

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To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

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P.O. Box 68760.

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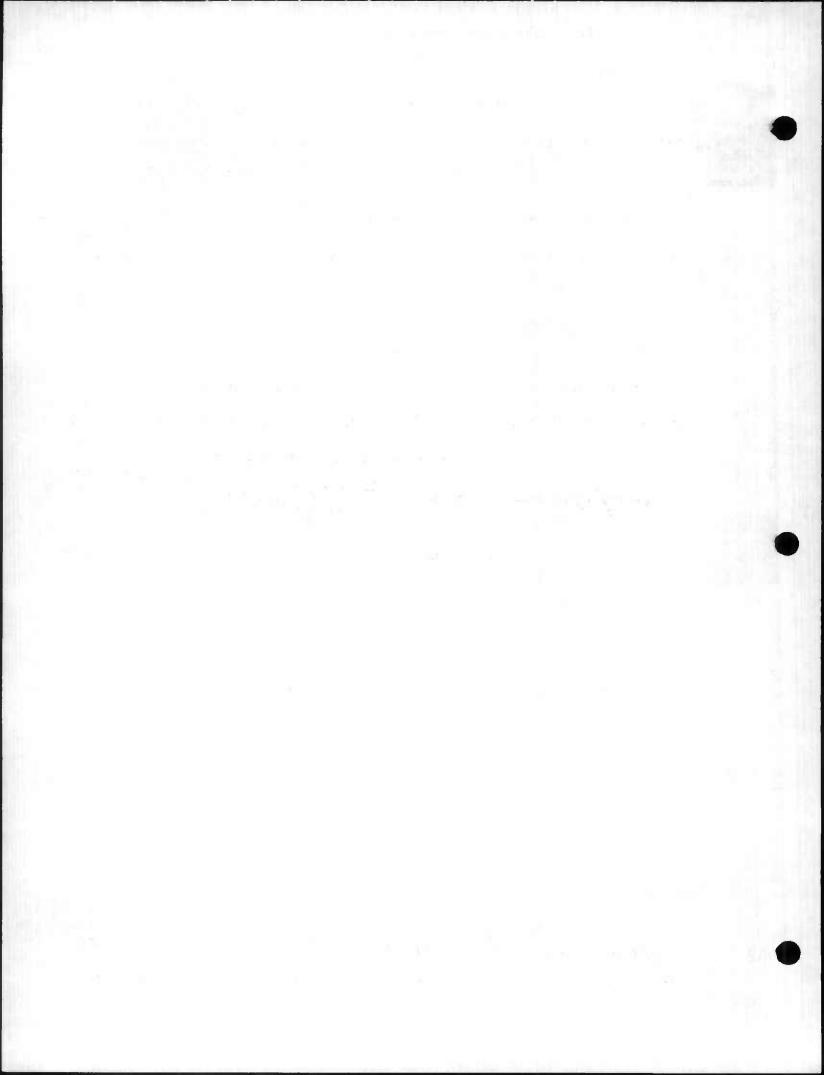
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Baltimore, Maryland 21215-0020

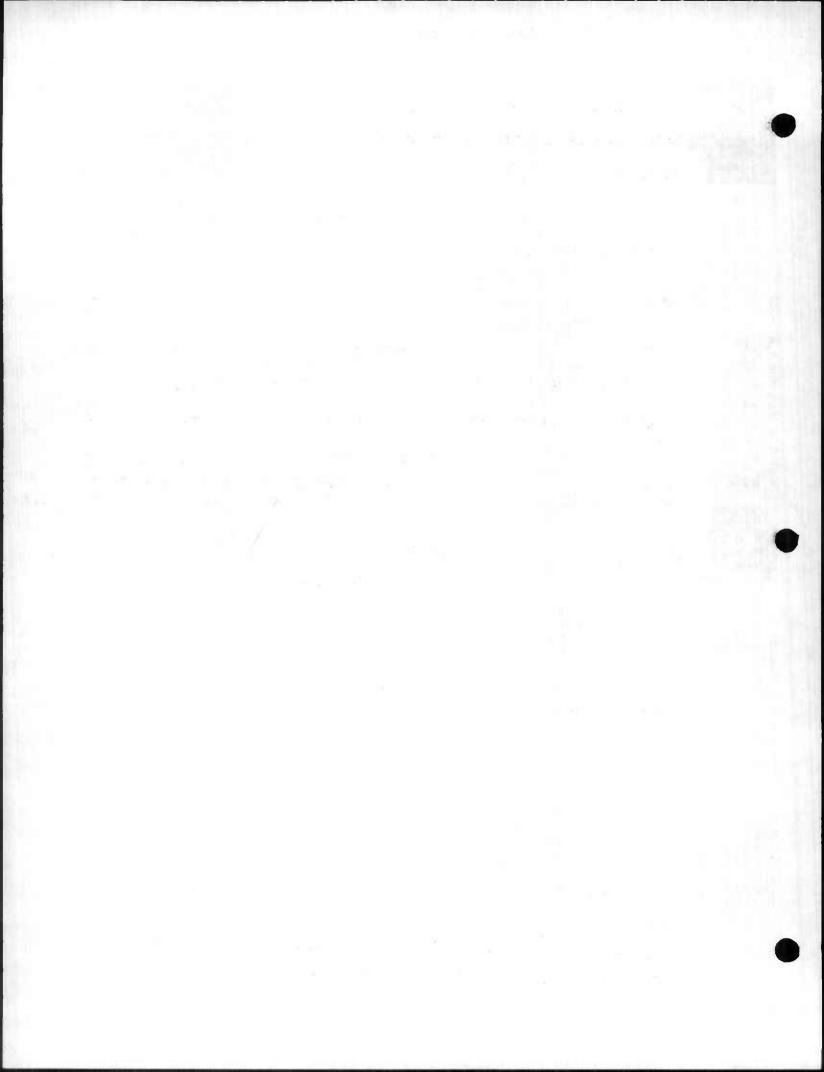
31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 20 199 Artia Davidson Randell

Daniel Rosenblum, M.D.



State of Maryland / Department of Health and Mental Hygiene Q

					Certific	cate of	Death		Reg. No.	10	101
Dhua	leiee	1. Decedent's Name (First, Middle, La	st)					2. Date of De		Yeer 3.	Time of Death
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Funera Directo		5. Social Security Number 6. S 578-32-9586 Usual Residence of Decedent	Sex 7. Age	(In yrs. last bir 88	Yrs. If U	nder 1 Year ths Days	If Under 24 Hrs Hours Min		th 19, Year) 2, 1909	9. Birthplace (Country) MARYLA	State or Foreign
fand fand		10a. State 10b. County	-1	Oc. City, Tow	n or Location					10d. In	side City Limits
Many a-f sh	to	N/A	N/A	DIST	RICT O	F COL	JMBIA			นั	Yes 2□No
th the	Director	10e. Street and Number			10f	. Zip Code			10g. Citizen of V	What Country?	
23a		3003 VAN NESS ST	REET NW			20008	3		UNITED S	STATES	
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Deficiency of the my or other		1 Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specif	THOMOVAL HOME STATE		ry, crematory SHOLOM			3-18-98			
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To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		ysician: To the best of r niner: On the basis of ex and manner state	amination and							ause(s)
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W		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)									
		LINDA M. BURRELL				E. #1:	345 CHEV	Y CHASE,	MARYLA	ND 20815	5
S	tate	31. Dete filed (Month, Day, Year)	32. Registrar's								



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and number)		4b. (City, Town, or Location of Death 4c. County of Death	1

Examin **Funeral**

Director permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinet must be notified at once.

Baltimore, Maryland 21215-0020

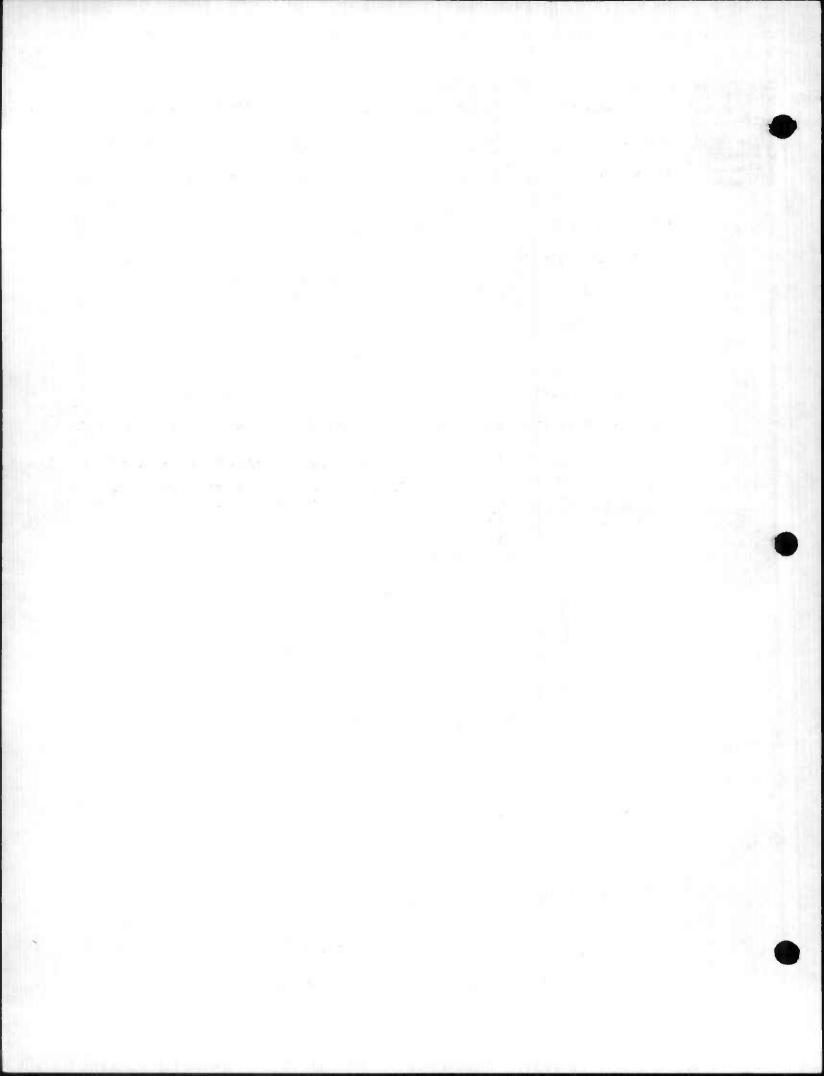
Physiclan /Medicai Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit Division of Vital Records, P.O. Box 68760,

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Physician /Medical Examiner Examiner Examiner Interest In	4a. Facility Name (If not institution, g	CA L. SP	PRAGGINS					te of Death	. No.	-	3. Time of Death
Funeral Director	STELLA MARIS 5. Social Security Number 579-68-5318					lb. City. Tow	-30	onth OTCH of Deeth	Day 4c. County	Yeer QQS	5:36pm
Director	579-68-5318		HOSPIT			BAL	TIMORE				
f show at at	Osual Meside Ide of Decedent	Sex 7. A 1□ M 3 € F	Age (In yrs. last birth	Months	Days	If Under 2 Hours	Min. /M	te of Birth onth, Day, Y ne3, 1	.951	9. Birthpl County [7a:	ace (State or Foreign try) Sh.DC
事 に	10e. State 10b. County MD Anne	Arundel	10c. City, Town	or Location vern						10	0d. Inside City Limits 1 X Yes 2 No
at be notified at Director	10e. Street and Number 7802 Statesm	an Stree	t	10f. Zip		144		10g	. Citizen of V		iry?
at, or items 234 Examinat must by Funeral	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ₹ If Yes, Give Year or Dates	ş? ∃No	13. Was Dece if Yes, spe 1 \(\text{Yes} \)		ispanic Orig in, Mexicen, Specify:	n? (Specify Yo Puerto Rican,	es or No- etc.)		e - America ck, White, e	
if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 23s-f show other traumatic event, the Medical Exemples must be notified at To Be Completed by Funeral Director	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th	Education rade completed) College (1-4or	16a. I	Decedent's Usu. (Give kind of wo life. DO NOT u Supply	al Occupion done of se retired	ation during most ficer	of working 16b. Kind of Business/Industry U.S. Governme				
atic event	17. Fether's Neme (First, Middle, Las Randolph Moo	•					s Name <i>(First</i> elia		lden Sumam		
27 is me or traume	19a. Informant's Name/Relationship Albert Sprag		19b. (sband)	Mailing Address			or Aural Aout in St.		-		
ury or oth	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery	Disposition (Nar v, crematory or o ngton N	ther plac	1 Cer	n. 3/25		c. Location -		wn, Stete
Important: if item 27 is any injury or other tra	21. Signature of Funeral Service Lice	Mos	udeu	22. Name ar SNOW ROCK	Addres	FUNE	RAL H	OME,	P.A.		
sician edical	23e. Part1. Enter the disease, or co- shock, or hear falure. List onl Immediate Cause (Final disease or condition	mplications that cause y one ceuse on each	- 1				erdiac or resp			١	Approximete Interval Between Onset and Death
aminer Je	resulting in death)	a	Due to (or as a co							1	
hysician and the buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	C	Due to (or as a co							1	
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page 2 should be det							24	4a. Was an a performe	utopsy d?	ava	re autopsy findings illable prior to inpletion of ceuse death?
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eral director	1 Yes 2 No	Hospital: 1 Inpat		patient 3 DC	Otho 28c. Injun Work	er: 4 🗆 Nur			e 6 🗆 Oth	er (Specify	IS AT MERC HOSPICE
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	Natural 5 Pending 2 Accident Investigati 3 Sulcide 6 Could not 4 Homicide determine	be 28e. Place of Ir	njury - At home, fari	М	1 🗆	K? Yes 2□N	28f. Lo	cation (Streety or Town, S		per or Rurai	Route Number,
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Tothy		ن	AM CAM	290	PO. License	9 8 2	9	290	Date signe	d (Month, L)ay, Year)
	30. Name and address of person who Sayedha G	completed cause of	death (Item 23a) (T			dge	and Ch	210-	th 20	2	



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	State of Ma	_			of Health a	ind M	nental Hy	giene 9	8	10184
. Decedent's Name (First, Middla, La	a#1		Cen	incate	of Death			Reg. No.		1070
	St)						2. Data of De Month	Day	Year	3. Time of Death
Helen E. Stack 1. Facility Name (If not institution, giv	a atract and number				4h City Toy	um or la	March :			10:20 AM
Holy Cross Hosp							ocation of Daath		ty of Death	
Social Security Number 6. S		(In yrs. last birt	thday)	If Under 1 Y	Silve	-			gomer	y place (State or Foreign
	□ M 2⊠ F		Yrs.	Months D	ays Hours	Min.	6. Date of Bird (Month, De Feb. 2	6, 1917	New	York
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. Father's Name (First, Middle, Last)	1				18. Mother	r's Neme	e (First, Middle,	Meiden Sume	me)	
John McGrath					H	elen	Seery			
9a. Informant's Name/Relationship (_		treet and Number					p Code)
Howard F. Stack	(hus	band)			ennes A	venu	e, Rock	ville,	MD	20851
a. Method of Disposition 1XI Burlal 2 ☐ Cremation 3 ☐	Domoval from State	20b. Place of cemeter	Disposi y, creme	ition (Name o	of r place)	ļ	Data	20c. Location	- City or T	own, State
4 □ Donation 5 □ Other (Specify		Gate o	f H	eaven	Cemeter	y 3	/20/98	Silver	Sprin	ng, MD
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Sa. Part. Enter the disease, or ective shock, or heart failure. Let ook	lications that caused to one ceuse on each line	he death. Do n			pring, l	MD	20901		West	Approximate Interval Between Onsat and Death
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Physician /Medical Examiner

Director

by Funeral

Be Completed

To

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hysiena. Important: If them 27 is merked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be notified at once.

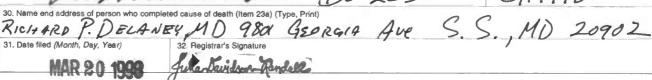
Baltimore, Maryland 21215-0020

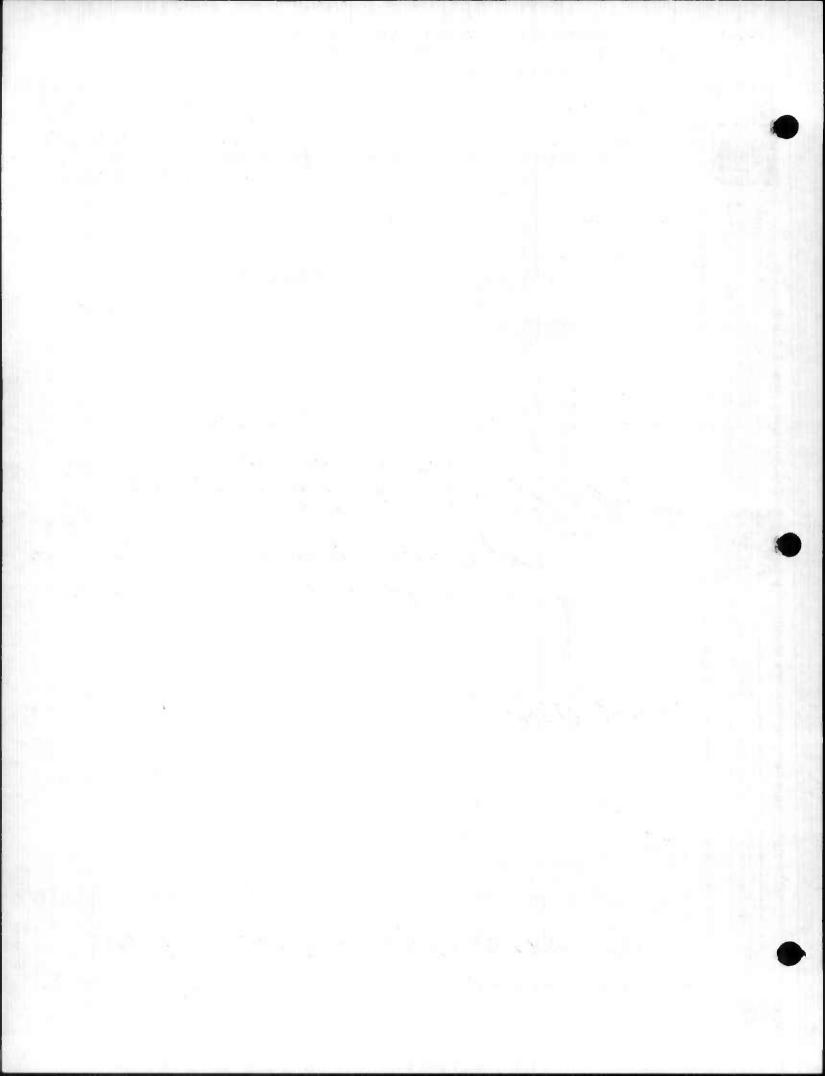
Examiner To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this cartificate hes been signed by the attending physician and ate hes been signed by the attanding physician and page 2 should be detached for use as the buriel-transit Division of Vital Records, P.O. Box 68760. Medical Certification: To Be Completed by Physician/Medical complately filled in by the funeral director,

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State Registrar





State of Maryland / Department of Health and Mental Hygiene \(\in \) Certificate of Death 2. Date of Deeth Dey

Physician /Medical Examiner

Funeral Director with the Maryland

Directo

Funeral

by

Completed

r is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar mant be notified at permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Haalth and Maniat Hygiene. Important: If item 27 is marked other than "natural; or items 23a any injury or other traumatic event, the Medical Examinet manall page.

> **Physician** /Medical Examiner

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Certification: To

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The law requires that the death certificete be executed

or Attending Physician:

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within 2 the

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) STAMBLER MARAWOH March 13, 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
lal Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. p. MONTGOMERY 8. Date of Birth (Month, Day, Year) June 21, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 1☐M 2☐ F Months Days Hours Min Yrs. 1928 578-30-4459 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Gaithersburg 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 20013 Octavia Court 20879 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 257 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Federal Government Economist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Golda. Rubin Stambler David 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20879 20013 Octavia Ct., Gaithersburg, MD Bette Stambler, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mar. 17, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Responsi from State 4 ☐ Donation 5 ☐ Other (Specify) 1998 Parklawn Memorial Park Rockville, MD 22. Neme and Address of Facility 21. Signature of Funeral Service Liceosee DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD acci 23a. Pany Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart larger List only one cause on each line. CEREBELLAR Immediate Cause (Final disease or condition resulting in death) Pecurrent LymphomA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 - No 1 TYPE 2 No 1 Yes 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

29a. Certifier (Check only one)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or trivestigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) D32407 MARCH 13, 1998

3. Time of Death

10:25 am

1 ☐ Yes 2 ☐ No

20877

Approximate Interval Between Onset end Death

2 Weeks

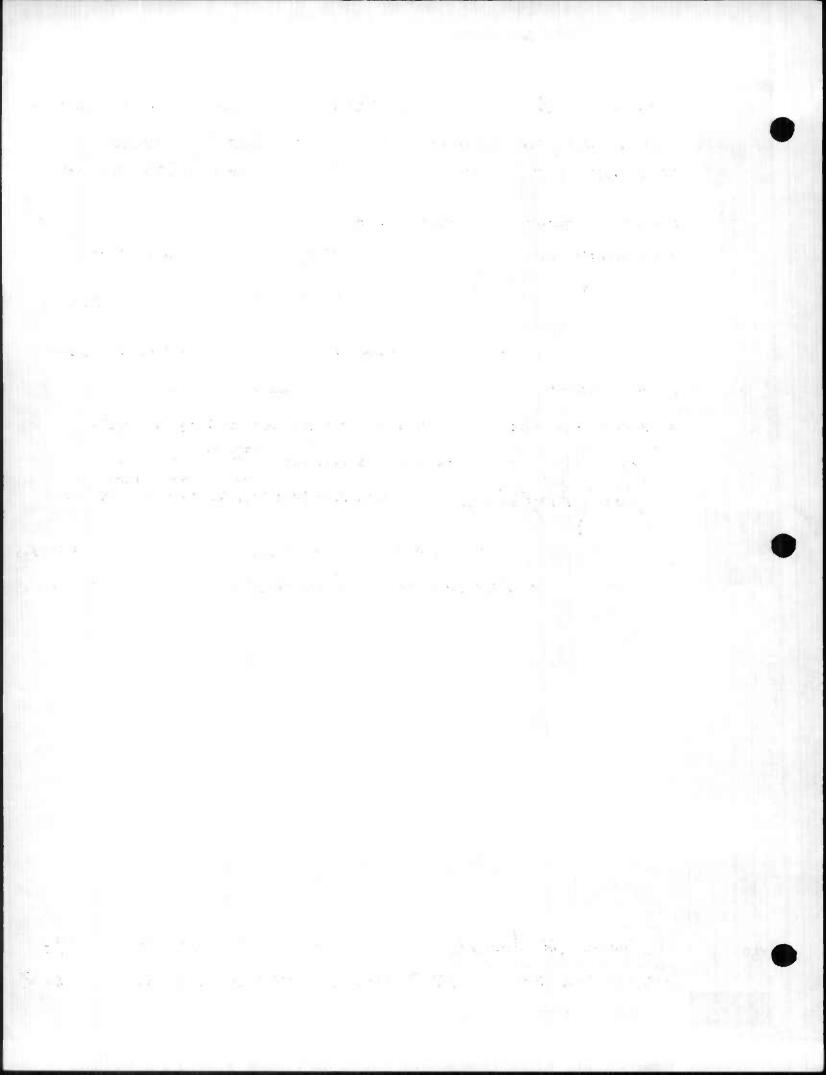
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL CENTER DR ROCEMUR ND 20850 9707 JOSEPH M. HAGGERTY MD 31. Date filed (Month, Day, Year)

State Registrar

18 1998 MAR

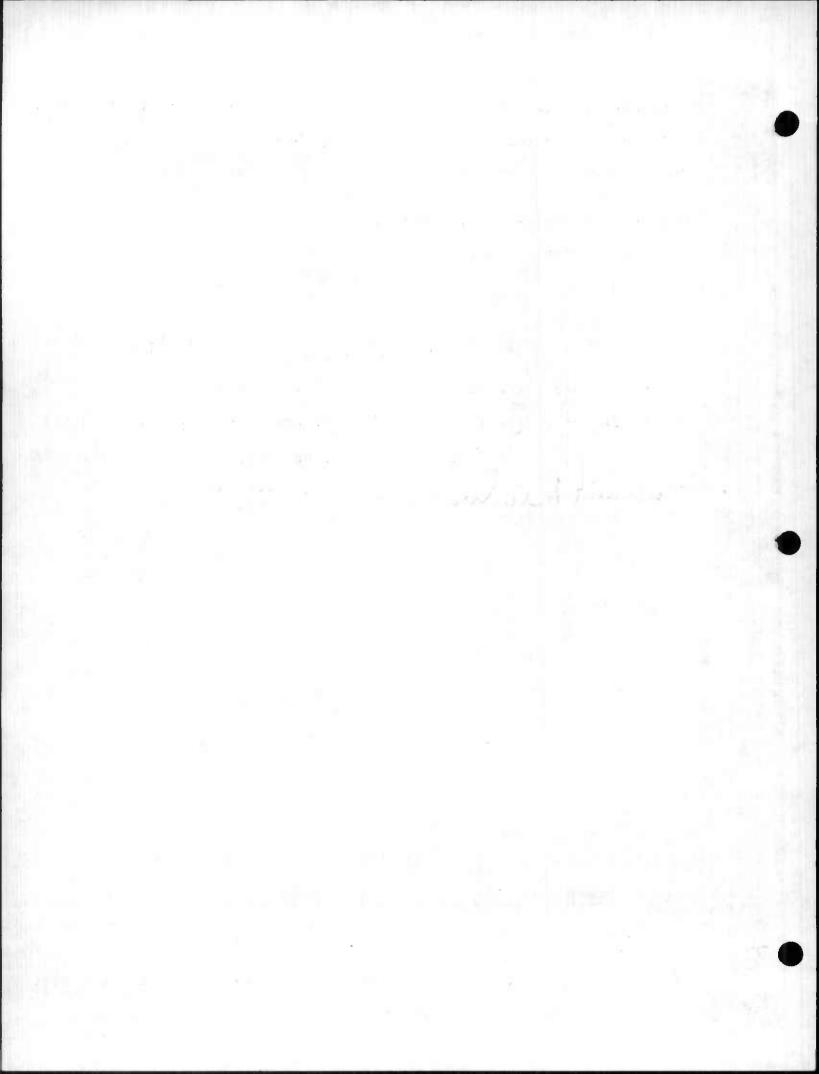
32 Registrar's Signature Sidia Davidson



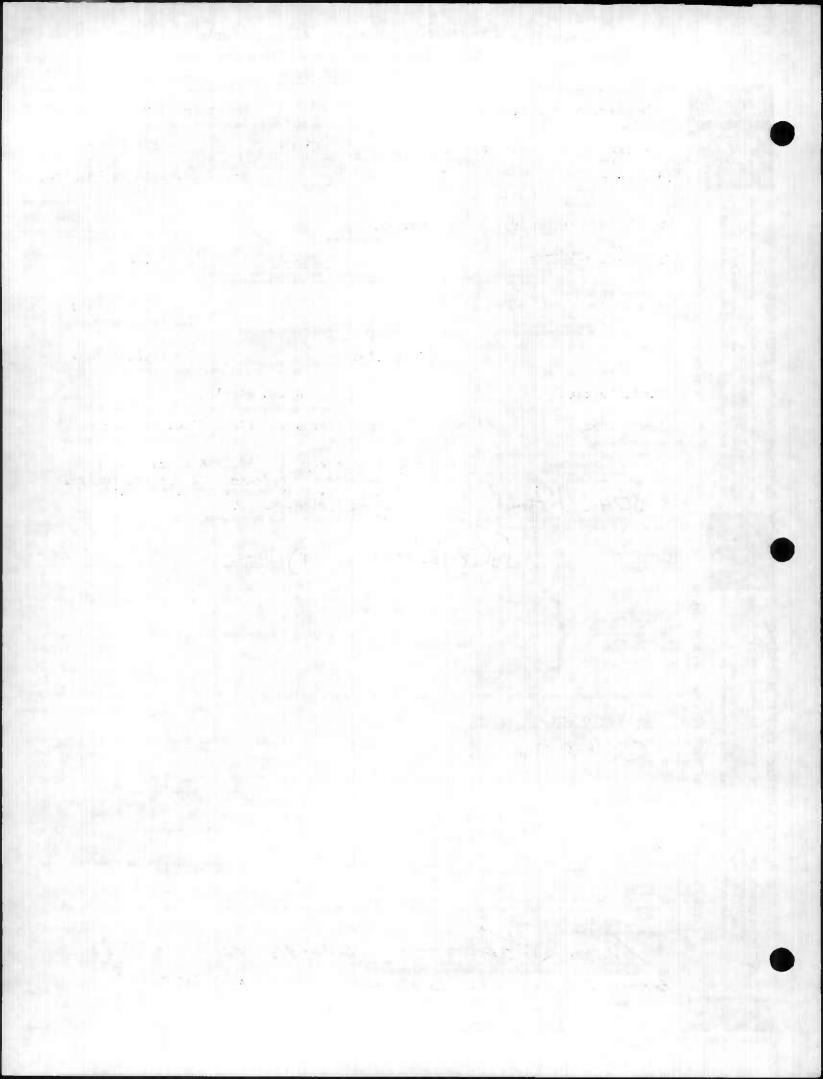
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15, **Physician** Month March 2:47pm Dorothy C. Stevens /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Jan. 8, I 914 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) 9. Birthplaca (Stete or Foreign Country)
PA **Funeral** 1 M XIXF 163-09-2056 84 Yrs Director Usuel Residence of Decedent filed within 72 hours efter death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow th and Menial Hygiene.
7 Is marked other than "natural", or items 23s or 28s-f show transetic avent, the Medical Exeminations to not the Director Y□Yas 2□No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown Rd. 20814 Funeral U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc. 1 ☐ Yas 2 ☑ No if Yes, Give ↑ Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Public School College (1-4or 5+) Speech Pathologist System ind Mental Hygie marked other t 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 should be f nent of Health and Mental I int: If item 27 le marked of Dora Unknown 0 David Mordecai Chedaker 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2.
Depertment of Health at Important: If item 27 le any injury or other trac Harold Stevens/Husband 9707 Old Georgetown Rd. Bethesda, MD 20814 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burlal 2 Cremation King David Mem. Gdns. 3/18/98 Falls Church, VA 4 Donation 5 Other (Se 22. Name and Address of Facility Ives-Pearson Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Acute Myocardial /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner Covenary The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consaquence of): signed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 No Unknown by Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to complation of cause of death? page 2 2) No certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 panpatient 2 ER/Outpatlent 3 DOA After this 27. Manner of Deeth Medical Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No Director: / 2 Accidant 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 125 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cartifies 29c. Licansa number 29d. Data signed (Month, Dey, Year) ma 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) A. Nimetz MD 5401 Western Ave. N. W. Washington, D.C. 31. Data filed (Month, Dey, Year) 32 Registrar's Signature State MAR 18 1998 Registrar



				State of M	naryian		irtment d tificate			Mental Hy	giene g	8 1	0187
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/Medical Examiner		a Facility Nama (#	not institution, give	a street and number	r)			41	b. City, Town, o	r Location of Deat	- 1	nty of Deat	h
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w w		9b. Signetura end	title of certifiar	1	2		29c. L	icansa	number				th, Day, Year)
		1/1	mans	Tow	_	_	D	06	176	an	3-	179	18
	3		iss of person who	complated causa of	death (Item	23e) (Type, 2 7-30	Print) UNIU	, .	BCUD	w. 0	WHE	TON	10902 CMM
State	:	11. Data filed (Monti		32. Ragis	trar's Signa	tura							
egistrar		MAD	1 9 1999	July	Davidson	Mandel	2						



State of Maryland / Department of Health and Mental Hygiene

s Are Legible.		
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ygiene 0	UI	00

1				State of IVI	arylariu	-	tificate of		i wientai riy	Reg. No.	1.0	/100	
		31	1. Decedent's Name (First, Middla, La	ist)					2. Date of De	eath		3. Time of Deeth	
	Physici /Medi			Ludmila	Μ.	Strug	er		March	11, Day 199	8 Year	12:12 PM	1
	Examir		4a. Facility Nama (If not institution, gir	a street and number)				4b. City, Town, o	r Location of Deat	h 4c. County	of Death		
			2206 Pecan Lane					Bowie		Prince	e Geo	rge's	
	Funeral Director		CT 010 DE1 000	Sex 7. Agr 1□M 2☑F	e (In yrs. las 49	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		12, 1948	9. Birthp Count AU:	lace (State or Foral) stria stria	חק
	dand www.		10a. Stata 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limit	S
	Man H	to	Maryland Prince G	eorge's	Boy	wie						1 XYes 2 N	0
	r 28a	Director	10a. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?	
	oth with the Marylar 23a or 28a-f ehow ust be nourfed at	alD	2206 Pecan Lane				20716			Canada	1		
Maryland 21215-0020	after dec or items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Vill Yes, Give Year or Dates:	Ever in U,S. No	1	Vas Decedent of H Yes, specify Cub ☐ Yes 🌣 No	dispanic Origin? (an, Maxican, Pue Specify:	(Specify Yas or No orto Rican, atc.)	14. Rad Bla Specif	ck, White,		
0	2 hor	be le	15. Decedent's E	ducation		18a. Deced	ent's Usual Occup	pation	STATE	16b. Kind of B			
218	d within 72 hours jiene. r than "natural", the Medical Exa	Completed	(Specify only highest gri	ade completed) College (1-4or 5	(+)	(Give I life. D	ent's Usual Occup kind of work done OO NOT use retire	during most of w d)	orking	rking			
21	ad withingiene.	000	12	00,000 (1,10,0		Fashio	on Design	ner		Textile	5		
Pu	tal H doth	Be	17. Father's Name (First, Middla, Last)					ame (First, Middle		ne)		
× a	Men Men arke	2	_John_Struger					There	sia Sam	onig			
Mar	2 sh le m le m	19a. Informant's Name/Relationship (Type, Print) James Blue (hus					-	and Number or I	Rural Route Numb	er, City or Town	State, Zip	Code)	
0	and lealth m 27 her to	James Blue (hus) 20a. Mathod of Disposition					ne as 10						
0	H ite		20a. Mathod of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from Slata	cen	natery, crem	sition (Name of natory or other pla		Date	20c. Location			
Ë	tant: tant:	1 Signature of Fueral Sarvice Licensee					ke Crema		1	.2-98 Beltsville, Marylan			
Baltimore,	Depar Impor any In	College W.			Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring.							1910	
100		23a. Part1. Entar tha disease, or complications the shock, or heart lailure. List only one cause or				Do not ente	er the mode of dyle	ng, such as cardi	ac or respiratory a	rrast,		Approximate Interval Between	
	Physician /Medicai Examiner	95	Immediata Cause (Final disease or condition resulting in death)			e sa consequ	iom you	iarcom	۵.			Onset and Death	
Box 68760,	eath certificate be executed ettending physician and for use as the buriel-transit	an/Medical Examiner	Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		s a consequ	,						
	v requires that the death cer been signed by the ettendir should be detached for use	Physician/N	Part II. Other significant conditions of	contributing to death bu	ut not resulti	ing In the un	derlying cause giv	ven in Part I.		tobacco use co		the cause of death	
Division of Vital Records, P.O.	Attending Physician: The law requires that the death cer refeath. sctor: After this certificate has been signed by the ettendin by the funeral director, page 2 should be detached for use	Completed by							24a. Was	an autopsy ormed?	ave	ore sutopsy lindings allable prior to mpletion ol cause death?	
<u>ac</u>	The ate he	Con							10	Yes 2 No	10]Yes 2∭ No	
/ita	slan: artific sclor,	Be	25. Was case relerred to medical axaminar?						eath (Check only	one)			
1	hysic his co	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		NOutpatient		4 LI Nuising	Home 5 Res	idence 6 DOth	er (Specifi	1)	
E C	oners uners	00:	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	28c. Injui Wo		28d. Describe	how injury occur	red		
Sio	death.	cati	2 ☐ Accident investigatio					Yes 2 □ No					
Ξ	or At efter of Direct in by	Certification:	4 ☐ Homicida determined	28a. Place of Inju	ry - At hom c. (Spacify)	e, farm, stre	et, factory, office		28f. Location ((Street and Numi wn, State)	ber or Rura	i Route Number,	
	29a. Certifier (Check only one) 12 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner s					To the best of my knowledge, death occurred at the time, date and piece, and dua to the basis of examination and/or invastigation, in my opinion, death occurred at the d manner stated.					and dua to	the cause(s)	
	≥ 29b. Signature and little of certifler					29c. License number 29d. Date signed (Month, Day, Year)					Jay, Year)		
D '	1 Calif						4465		03/1	1/46	>		
30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Ann C. Majey, M.D. 900 Bestgote Road, Annapo 31 Date Illed (Month Day Year) 32 Replactor's Signature					\	,	-	1					
AM C. Maney, M.D. 400 Bestgste Kozd					020 F	modeun	3/1110	21	101				
State 31. Date Illed (Month, Day, Year) 32. Registrar's Signature MAR 16 1998 July Davidson - And State													

#5 fee E. Rapp (Funeral Director) the SI # is CAMADIAN Social Security Number Family Requested it Also to be listed Also.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician
/Medicai
Examiner

1. Decedent's Nama (First, Middia, Last)

SENSIBAUGH

2. Deta of Death Month

3. Time III Country 2:23 PM

10d. Insida City Limits

WHITE

Approximata Intarval Between Onsat and Death

12 months

1 Yas 2 No

Funeral Director

Director

Funeral

þ

Completed

Be

0

the Maryland death

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Healin and Mental Hydiene. Important: If flem 27 is marked other than "natural; or flee any injury or other traumatic event, the head of Evantments. Pages nent of h

Baltimore, Maryland 21215-0020

Box 68760.

P.O. |

Records,

Division of Vital

Physician /Medical Examiner

Examiner buriel-transit end physician Physician/Medicai the ettending 0 the signed by t þ Completed peen hes page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

DELORES 10, 1998 MARCH 4e. Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Daath 4c. County of Death 623 CAROLYN ROAD ANNE ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 6. Deta of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 1□M 21 F 215-30-0884 66 Yrs. 02-10-1932 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location ANNE ARUNDEL MARYLAND GLEN BURNIE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 623 CAROLYN ROAD 21061 U.S.A. 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2X No If Yas, Giva Yaar or Detes: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Merried 2K Married 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) Collaga (1-4or 5+) 12 N/A PERSONNEL MANAGER FORT MEADE 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumama) LAWRENCE WADE HAZEL REIMSNYDER 19a. Informent's Name/Ralationship (Type, Print) (HUSBAND) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) NORMAN EDWARD SENSIBAUGH 623 CAROLYN ROAD, GLEN BURNIE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Nama of cametery, cramatory or other place) 20c. Location - City or Town, Stata 1 🛱 Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 5- Bing (Specify) GLEN HAVEN MEMORIAL PARK! 3/13/98 GLEN BURNIE, MD. 21. Signature of Funeral Service I Icansaa 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part I. Effer the disaase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Immediata Cause (Final metastatic colon concer diseasa or condition rasulting In death) Due to (or as a consequance of): Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that Initieted avents resulting in daath) Last Due to (or es a conseguança of) Due to (or as a consequanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

1□ Yes 2☑ No

1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of daath?

1 ☐ Yas 2 ☐ No

25. Was casa referred to medical 1 Yas 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Tima of

26. Pleca of Deeth (Check only ona) 28c. Injury at Work?

Othar: 4 Nursing Homa 5 Aasidanca 6 Othar (Specify)

1 Natural 2 Accident 3 Suicida 4 Homicida

5 Panding Invastigation 6 Could not be detarmined

1 ☐ Yas 2 ☐ No 28e. Plece of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

29e. Certifian (Check only one)

Descritiving Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to the cause(s) and menner as steted. 2 Madical Examinar: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated.

29b. Signatura end titla of certifier

31. Data filed (Month, Day, Year)

29c. Licansa number

29d. Dete signed (Month, Day, Year)

MAR 13 1998

- Oltamo

140850

March 11, 1998

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print)

YVONNE OTTAVIANO 900 CATON AVE BALTIMORE MD 21229 MD

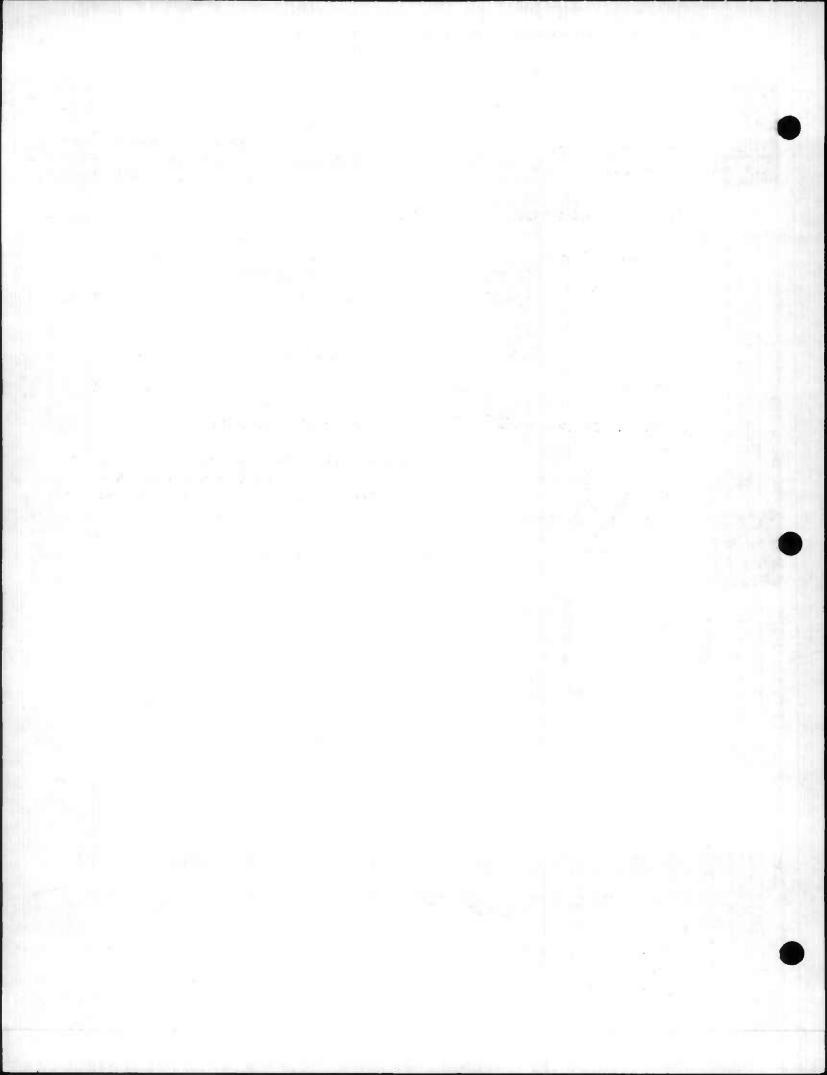
State Registrar

Medical

32 Registrar's Signatura

Signatura

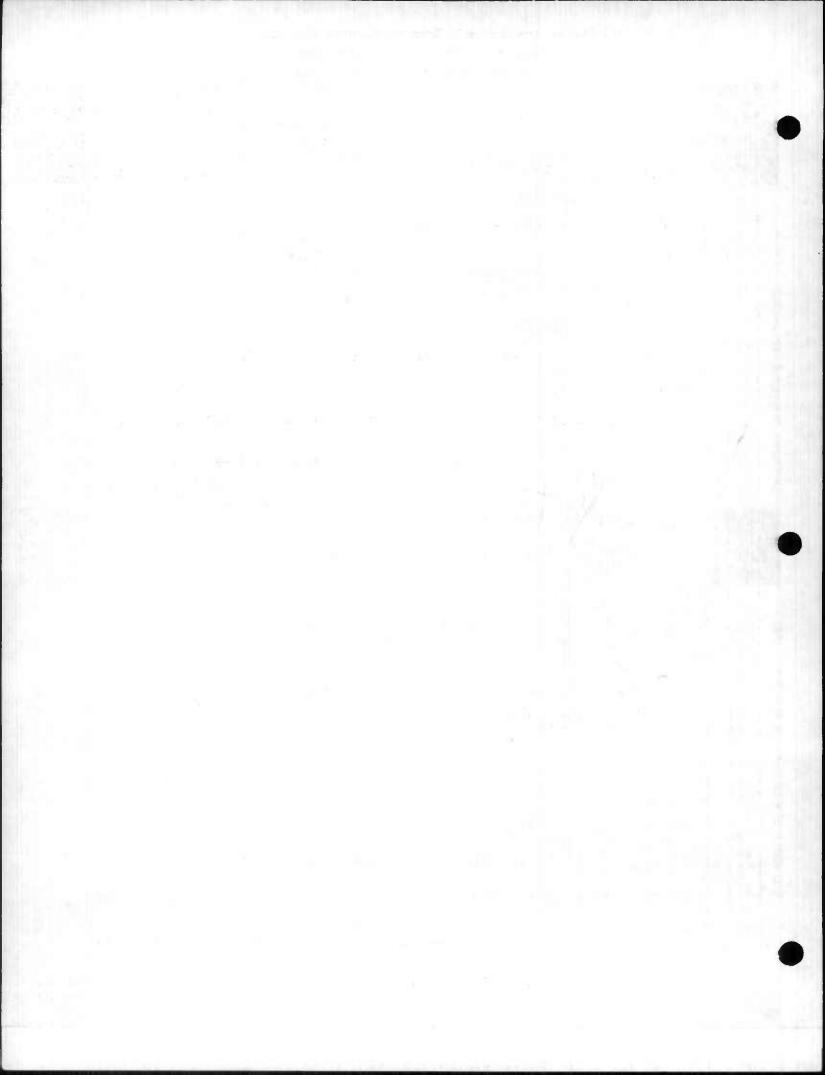
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MD 81146

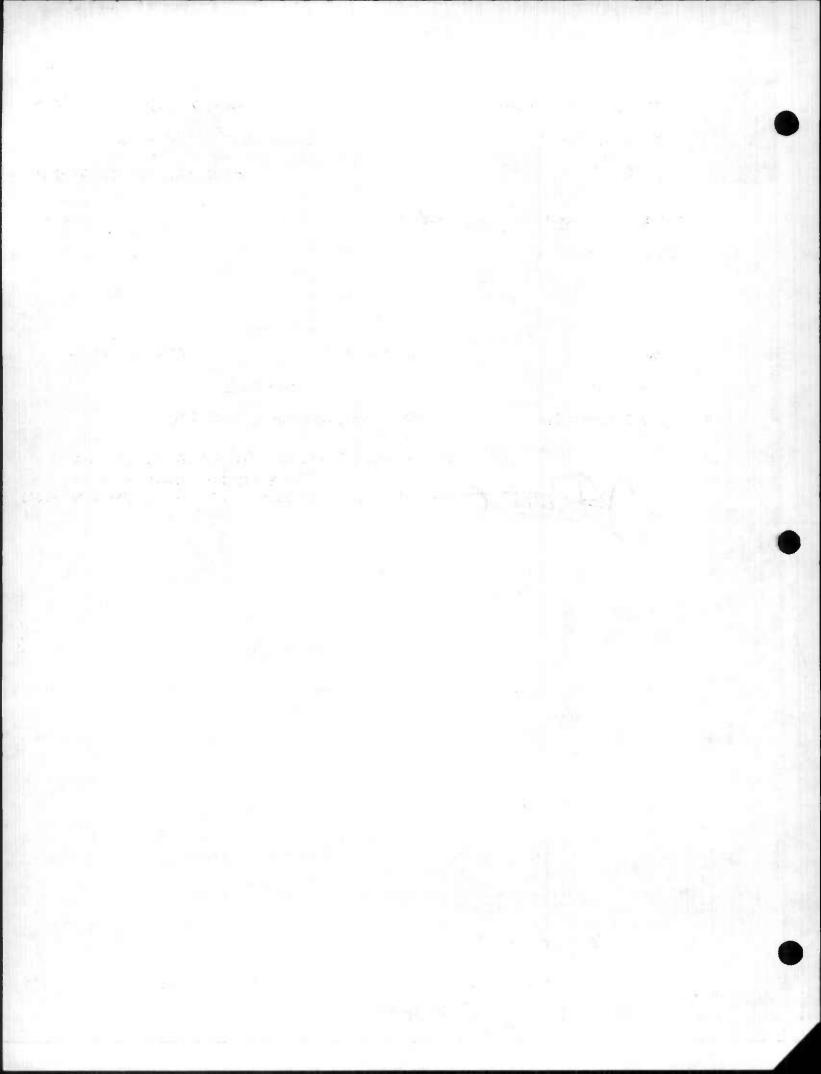
				State of Marylar		epartment of Certificate of		Mental Hy		3	0190
			Decedent's Neme (First, Middle, Last)					2. Dete of De	Reg. No.		3. Time of Death
	Physic /Medi	cal	FRANCIS L. 4e. Facility Neme (If not institution, give s	INCOLN	SU'	TTON	4b. City, Town, or L		Dey 10 - 19		2:00 AM
_	Examil Funeral Director	ner	606 KENT AVE. 5. Social Security Number 6. Sex			nday) If Under 1 Year Months Days	PASADENA If Under 24 Hrs.	8. Dete of Bi	ANNE	ARUNI 9. Birthple Country	ce (Stete or Foreign
	sa-f show	Director	10e. Stete 10b. County MARYLAND ANNE ARU		ty, Town	or Location				100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the		10e. Street end Number 606 KENT AVE.			10f. Zip Code	21122		U.S.A.	Vhet Countr	y?
020	within 72 hours effer death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madical Exercine must be incutified at	by Funeral	11. Maritel Stetus 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	J,S.	13. Wes Decedent of If Yes, specify Cut		ecify Yes or No Rican, etc.)	o- 14. Reco Blec Specify	e - Americer k, White, et	c.
O	2 ho	ted	15. Decedent's Educ	cation		Decedent's Usuel Occu			16b. Kind of Bu		
d 21215-0020	Hygi ther ther	Be Completed	(Specify only highest greds Elementary/Secondary (0-12) 12 YEARS 17. Fether's Neme (First, Middle, Last)	College (1-4or 5+) 4 YEARS		(Give kind of work done life. DO NOT use retire	ed)	NAGER	INSURANO		1PANY
a	should be od Mental marked o matic sve	To B	HERBERT SUTTON				MARION		WHITHAM		
Maryland	alth end Men 27 is merks r trsumatic		19e. Informent's Neme/Reletionship (Ty) JEAN M. SUTTON-WIF			Mailing Address (Stree				State, Zip C	Code)
more,	00-		20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ R	20b. I	Pleca of	Disposition (Name of c, crematory or other ple	1	Dete	20c. Location -		n, Stete
=	tant:		4 Donetion 5 Other (Specify)	CHI	ESAP	EAKE CREMAT	CORY, INC.	-12-98	BELTSVI	LLE,MA	ARYLAND
Bal	permit. Peg Depertment Important: It any injury o		21. Signeture of Funeral Servica Liberal	-		22. Neme end Addr	TH		LETON FUI		
	Physician /Medical Examiner		23e. Pert1. Enter the dilease of complishook, or heart fell unit only on Immediate Ceuse (Final disease or condition resulting in death)	ations that caused the deel ceuse on each line.	th. Do no		ing, such es cardiec		errest,	1	Approximate Interval Between Onset and Death
_	D #	iner	- 1	ang Ro	or es a co	onsequence of):					
Box 68760,	deeth certificate be executed e ettending physician and of for use es the bunal-transit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	pulu	one	onsequence of):	slegrem	_			
ă	s ette	icla	Pert II. Other eignificant conditions con	tributing to death but not rec	ultino in	the underlying cause of	von in Dart I	22h Did	tohaana uga aar	ntelhude to t	he cause of death?
P.0		by Physician/Me		utive he		/ . /			Yee 2 No		bly 4 Unknown
Records,	been s	Completed b				<i>V</i>			s en eutopsy ormed?	avail	e eutopsy findings eble prior to pletion of cause eeth?
	The lew ate hes page 2	S						10	Yes 2 No	10	Yes 2□ No
Vital	defant: The certificate rector, pag	Be	25. Was case referred to medical exeminer?	e en itali			26. Plece of Deel	h (Check only	one)		
5	Physical direction	- To	1 Yes 2 No	A CONTRACTOR OF THE PARTY OF TH	ER/Out	Detient 3L DUA	her: 4 Nursing Ho		Idenca 6 Oth		
DIVISION	Attending Physician: or death. ector: After this certific by the funeral director,	Certification:	Neturel 5 Pending Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Ti	jury Wo	rk? Yes 2 No		how Injury occur		
2	tal or Attand rs efter death al Director: ed in by the	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, fen	m, street, fectory, offica			(Street end Numb own, Stete)	er or Rurel i	Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Director completely filled in b	edicai (29a. Certifier (Check only one) 2 Medical Examin	Icfan: To the best of my known: On the basis of exemine end menner stated.	owledge, etion end	deeth occurred et the t for Investigation, in my	ime, dete end plece, opinion, deeth occur	end due to the red et the time,	ceuse(s) end me , dete and plece,	end due to t	led. he ceuse(s)
	To the within To the comp	M	29b. Signature end title of certifier	Sozai		29c. Licen	se number) 8 3 8 7	2	29d. Date signed	d (Month, Di	ay, Year)
			30. Name and eddress of person who con	mpleted cause of deeth (Iter		Type, Print)	FPS ItnIF	RN -	T 204 6	SP 188	NA DARM

State Registrar



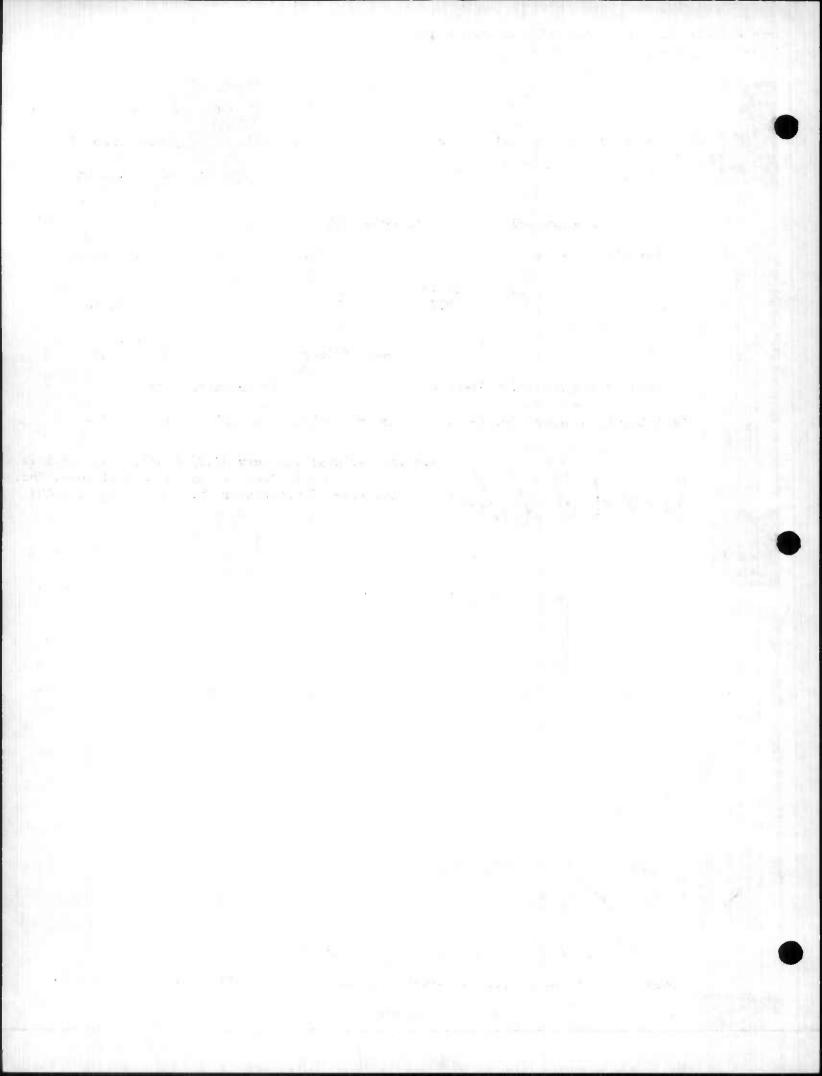
State of Maryland / Department of Health and Mental Hygiene

_						Cen	tificate of		1	eg. No.	- 1	1191
п	Physic	ian	Decedent's Name (First, Middle, Last,						2. Date of Deal	Day	Year	3. Time of Death 9:00 PM
	/Medi	cal		Stewart					March 7	-		9:00 PM
	Exami	ner	4a. Facility Name (If not institution, give					4b. City, Town, or L		4c. County o		
	11 1		503 Walnut Street 5. Sociel Security Number 6. Sec				lf Linday 1 Vons	Church H		Queen		
	Funeral Director			7. Age	71	Yrs.	Months Days		8. Date of Birth (Month, Day) September	13, 1926	9. Birthpli Count West	ace (State or Foreign ry) t Virginia
	land		10e. State 10b. County		10c. City,	Town or Loc	ation				10	d. inside City Limits
	Mary Fig.	ţ	Maryland Queen Ar	me's	Chur	ch Hill						1 ☐ Yes 2 No
	7 28g	ě	10e. Street and Number				10f. Zip Code		1	Og. Citizen of WI	nat Count	rv?
	s 23a o	Funeral Director	503 Walnut Street				21623			U.S.A.		
0200	2 should be filed within 72 hours after death with the Maryland and Mental hygiene. Is marked other than "natural", or items 23a or 28a-f show farmatic event, the Medical Examination must be northed at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:			As Decedent of I Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race Black Specify:	White, e	etc.
21215-0020	rithin 72 h	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	+)	(Give k life. D		during most of worked)	ing	16b. Kind of Bus		
7	No th		Eleven			Owner &	Operator			Welding S		≥ Co.
and	tal H dot	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam		Aaiden Sumame,)	
2	Mer Marke	2	James Taylor					Mabel S				
Σ	elth a 27 is		19a. informant's Name/Relationship (Ty.) Lloyd T. Stewart/Son	oe, Print)		8635 Oa	ak Road, E	and Number of Aur Saltimore, M			tate, Zip	Code)
ore Ore	or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		20b. Piac	ce of Dispos	ition (Name of atory or other pla	ice)	Date	20c. Location - C	ity or Tov	m, State
Ē	nut Pagas arriment of I ortant: If ite Injury or o		4 □ Donation 5 □ Other (Specify)	amoval from State				ark/March	11, 1998	Glen Burn	ie, M	aryland
baitimore,	permit. Pagas 1 e Department of He Important: If frem any Injury or othe once.		21. Signature of Juneral Sandor License	0		22.	Name and Addre	ess of Facility SIN	GLETON E	UNERAL	HOME	, P.A. LAND 21061
*	No.		23a. Part1. Enter the disease, or compliance, or head falled Liter only on	cations that caused	the death.	Do not enter						Approximate
	Physician		shock, or head salds. List only on									Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition	M	ofas	tatio	, Bre	ast Ca	ncer		1	1400/
	Examiner		resulting in death)	,		s a consequ					1	The state of the s
н	D #	ner									1	9
ń	death cartificate be axecuted a attanding physician and of for usa as the bunel-transit	Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	С	ue to (or a	s a consequ	ence of):					
09/90	ysicia ysicia	Cal	triat mitiated events		ue to (or as	s a conseque	enca of):				-	
0	artifica ing ph a as th	Medical	resulting in death) Last									
200	aath car attandir I for usa	Physician/	d		-							
	a daa ha at ned fo	sic	Part It. Other significant conditions con	ributing to death but	not resulting	ng in the und	derlytng cause gi	ven in Part t.	23b. Did to	bacco uae conti	ribute to	the cause of death?
7, 7.0	s that the ned by e datacl	by Phy	Mali	gnart	Ple	wal	offe.	sim	1 🗆 Ye	250 No 3	B 🗆 Prob	ably 4 Unknown
necords,	law requires that the de as been signed by the 2 should be datached	Completed					, .		24a. Was a		corr	re autopsy findings ilable prior to apletion of cause eeth?
	Tha ata h page	50							1 □ Ye	s 2546	1 🗆	Yes 2□ No
Vital	slan: artific actor,	Be	25. Was case referred to medical examiner?					26. Place of Deat				
5	Physician: r this cartifica aral director,	ဥ	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatien		VOutpatient	3□ DOA Ott	ner: 4 Nursing Ho	me 5 P Reside	nca 6 □Other	(Specify)	1
5	tending P death. tor: After t the funer	tion:	27. Menner of Death 1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. inju Wo M 1	ry at rk? Yes 2 □ No	28d. Describe ho	w Injury occurred	t	
DISION	To the Hospital or Attending within 24 hours after death. To the Fuveral Director: After completely filled in by the fune fune	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Ptace of Injur building, etc.	y - At home (Specify)	e, farm, stree			28f. Location (St. City or Town		or Rural	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	cian: To the best of er: On the basis of e and manner state	examination	dge, death of and/or inve	occurred at the til stigation, in my o	me, date end plece, opinion, death occurr	and due to the ca red at the time, da	use(s) end menr ite and piece, an	ner as sta d due to t	ted. the cause(s)
	ompl	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed								Month, D	ay, Year)
	->=0		non	es P			H	4755	27	2/9/1	(0)	
			30. Name and address of person who cor	npleted cause of de	ath (Itam 23	3e) (Type Di	rint)	100	5 1	0/1/9	0	-
			Russell Schill					rilla DA	Cont	revill	0	MA 2161
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				State of Maryla			of Health and I of Death		giene Reg. No.	}	0192
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	/Medi	cal	Carl Ludwig				ah Cibi Tourn or l	March	6 199		11:16 PM
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21215-0020	within 72 hours iana. than "naturs!", the Medical Ex.	Completed	15. Decedent's Edu (Specify only highest grade Elementery/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I life. D	ONOT use re	one during most of wor etired)	king	16b. Kind of Bu	cal	
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	To the Hospital within 24 hours of the Funeral complately filled	edicai	29a. Certifier (Check only one) 1 Certifying Phys	iclan: To the best of my knier. On the basis of examina	owledge, deeth ation and/or Inv	occurred at the estigation, in a	ne time, dete end place my opinion, death occu	, and due to the orred at the time, o	cause(s) end me date end plece, a	n <i>n</i> er es sta and due to	ited. the ceuse(s)
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			30. Name and address of person who co			Print)	*				
			Robert T. Peterso			Avenu	e Annapolia	s, MD 21	401 (410)-266	-1644)
	Sta Registr		31. Date tiled (Month, Dey, Year) MAR 11 1998	32 Registrar's Sign	ature on-Randa	82					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Glenayre Key Shannon 1998 6 4PM March 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 X F Yrs. 82 Dec 16 1915 214-38-5935 Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XXes 2 □ No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 161 Williams Drive 21401 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ Xo Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondery (0-12) College (1-4or 5+) 12 Naval Academy 1 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Key Margaret Kells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Shannon (Husband) Annapolis, Maryland 21401 161 Williams Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mil/crest Memorial Cemetery 3/11/98 Annapolis, Maryland 21 Senature of Funeral Sprvice Lightsee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 Part | Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) SUBDURAL HEMATOMAS Due to (or as a consequence of): SYNCOPE Due to (or as a consequence of): Due to (or es a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed?

Physician /Medical Examiner

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Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Physician/Medical

1 Yes ZO No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manger of Death 28d. Describe how Injury occurred Natural 5 Pending Investigation 3/6/98 4:00 PM 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

29a. Certifier (Check only one)	1 ✓ Certifying Physicien: To the best of my know 2 ☐ Medical Exeminer: On the basis of examination end manner stated.	ledge, death occurred at the time, date end place, and du on and/or investigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. the time, date end place, and due to the ceuse(s
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enned 30. Name and address of present who ompleted cause of death (Item 23a) Type, Print) D44837

MEDIAL PARKWAY, ANNAPOLIS, MARYLAD KENNEDY 2003 31. Date filed (Month, Day, Year, 39. Registrar's Signature Julia Davidson-Mandalle MAR 11

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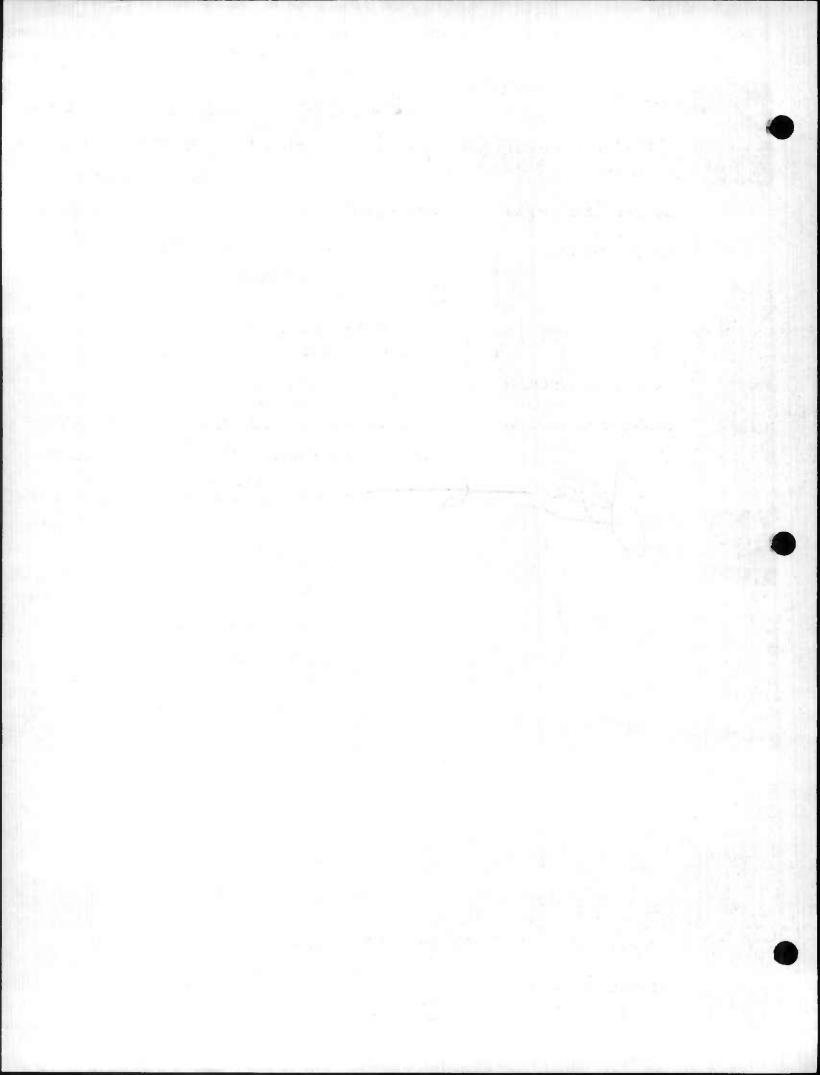
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State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1998 1:00 pm 08 tric March /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Aga (In yrs. last birthdey) Hnne Burnie unde if Under 24 Hrs. 6. Sex 1 M 2 F If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** Months Days Hours 94 084-09-6913 Director 9/19/03 GERMANY Usual Residence of Decedent the Manylend 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at ANNE ARUNDEL GLEN BURNIE MARYLAND 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 105 SANSBURY AVE. U.S.A. Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1 ⊠ Yes 2 □ No 1942 − If Yes, Give Yaar or Datas: 1964 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 1 No Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: if len 27 Is marked other than "n any Injury or other traumatic event Elementery/Secondery (0-12) College (1-4or 5+) ADMINISTRATIVE U.S.GOVERNMENT 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Melden Surnama) DIETRICH W. SCHROEDER ANNA MEINDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HANNELORE L. SCHROEDER GLEN BURNIE, MARYLAND 21060 105 SANSBURY AVE. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other plece)
ARLINGTON NATIONAL CEMETERY 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State FT. MYERS, VIRGINIA 5 Other (Specify) 4 Donation 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE., SW GLEN BURNIE, MARYLAND 21061 Los conclications that causad tha daath. Do not anter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximete interval Between Onset and Death Physician /Medicai Immediat Car a (Final disaase or Indition resulting in death) Examiner (or as a consequence of): Examiner physician and the burial-trensit Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, in Physician/Medical Due to (or as a consequence of): signed by the ette Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certified 25. Was cese referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 28. Piace of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1. Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Yeer) 28c. injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1- Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 ■ Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier 29c. License number 2 8 7 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifiar 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 479 Jumpers Hole Road Benjamin James J. Severna PArk md. 31. Date filed (Month, Dey, Year) MAR 1 0 1998 32. Registrar's Signature

hia Davidson-Randell

State Registrar

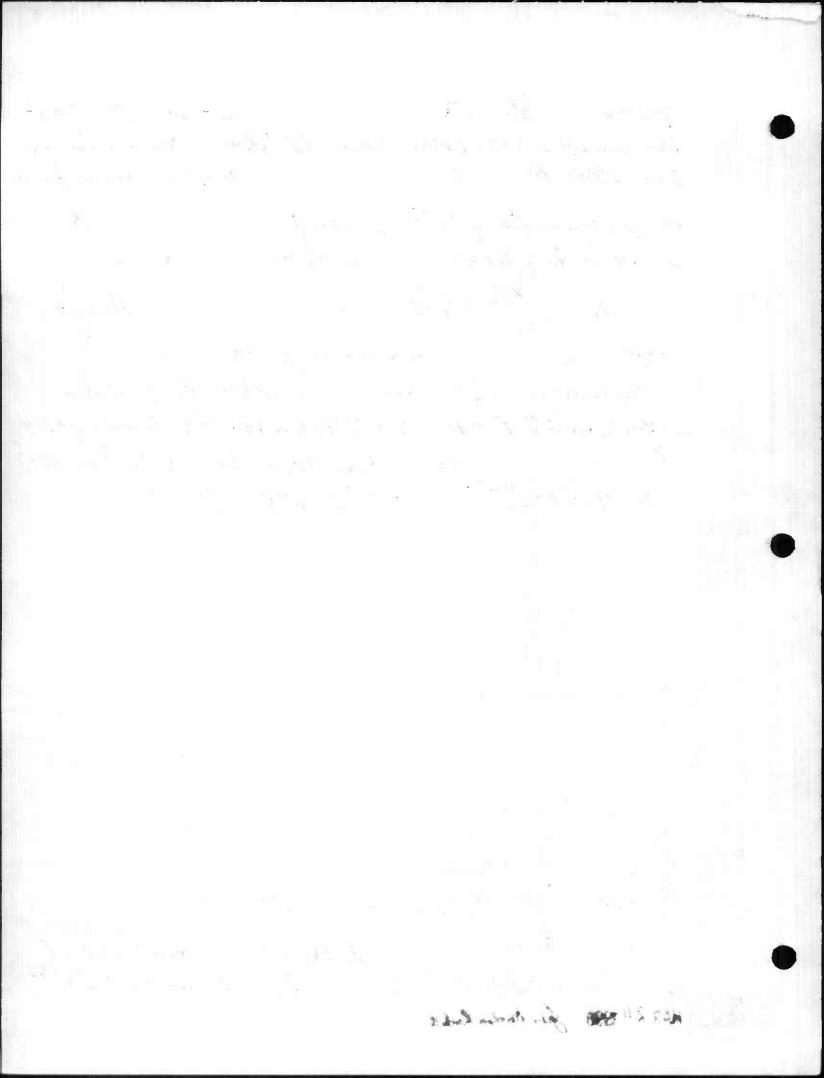


State of Maryland / Department of Health and Mental Hygiene

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Baltimore,	permit. Pages 1 and 2 should be filed Department of Haalth end Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, once.		21. Signature of Funeral Service Lice	/	/	LICET	ame end Addre	Macamac	III Fune	eral Hon	ne, P.	Α.
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N	or Al after Direc in by	it a	4 Homicide determined	200. Placa of III	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)				City or To	cation (Street end Number or Rural Route Number, y or Town, Stete)		
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	u		30. Name and address of parson who PAUL COLPYNO	, MD 65	709 M	V, C	hours	57	BALTY	3/1	10 2	21204
	Sta Registr		MAR 1 7 19	98 June 6	d's Signeture	Kardall				/		

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			and the state of t	n	rince	Heorge
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	0	200 Contilier ATCOutted Objects Table 1			
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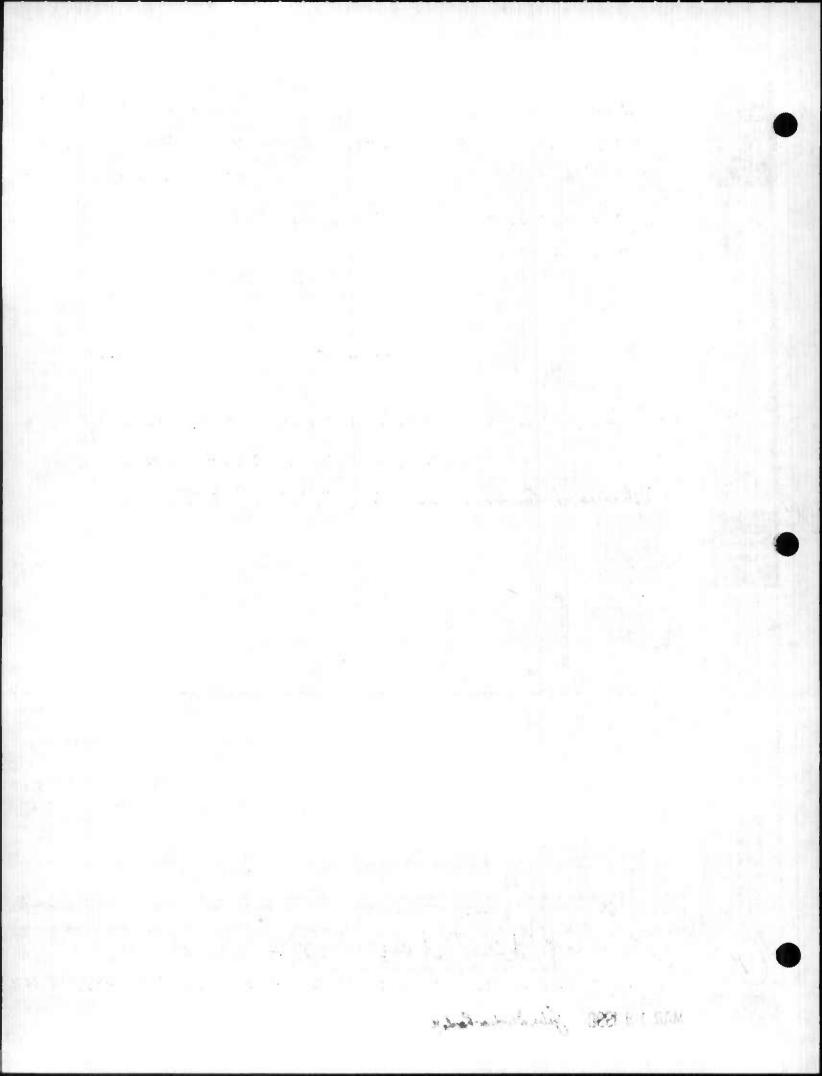


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1	128		29b. Signature end title of certifier	BUDG	Dul	Pin	E D3	3954			18, 1998	
(19		30. Name and eddress of person who con MARIO F. GOL	npleted cause of de	eth (Item 23a)	(Type, P		TAL DRIV	E, CHE	WERLY	18, 1998 MARYLA	ND 20

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. FOUND 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Tima of Death 05:16 Pm Month **Physician** Charles G. Sibert 1998 MARCH 14 /Medical FOMO 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Camp Springs 5214 Morris Avenue PRINCE GEORGES 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth January 15, 1937 Birthplaca (Stata or Foraign Country) Funeral Hours 1**XX**M 2□ F Months Days 249-56-8854 61 Yrs. Director South Carolina Usual Rasidanca of Decadant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Mary land Prince George's Camp Springs Director 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5221 Morris Avenue 20746 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yas 2 🛱 No 11 Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Spacify: **Black** by 3 Widowed 4 Divorced Year or Dates Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 5th grade ntery/Secondery (0-12) Collega (1-4or 5+) Brick Mason George Hyman Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be Earl Sibert Sulla Mae Sibert 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 5221 Morris Avenue Apt. #104 Camp Springs, Maryland 20746 Charlene Moore (Daughter) 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Chesapeake Crematory, Inc. 3/23/98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) of Funeral Seg 21. 56 22. ROTT THE PURE FAT HOME, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 uson iter the diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on eech line. Approximate intarval Batween Onsat and Death Physician Immediata Causa (Final & AKTERIOSCUEROTIC CARPIOVASCULAR DISEASE disaasa or condition resulting in daath) Dua to (or as a consequance of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initioled events resulting in death) Last Dua to (or as a consequance of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ETHANOL ABUSE þ Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) examinar' Hospital: 1 | Inpatient Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mennar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturel 5 Panding Invastigation 1 Yas 2 No

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. 29a. Cartifier

29b. Signatura and title of certified

29c. Licensa number 29d. Data signed (Month, Day, Year)

MARCH 19, 1998

DIME nh (Item 23a) (Type, Print)

GOLDE MD HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 MARIO TK 3001 31. Data filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

I or Attend after death Director: /

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Louis March 2:00 pm 18 (If not institution, giva streat end number) 4b. City, Town, or Location of Death 4c. County of Death WTher MAC 5. Social Security Number 7. Aga (In yrs. lest birtheay) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Yrs 577-62-6743 96 25,1901 Washington, D.C. Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yes 2 No Maryland Prince George's Clinton 10e. Straat end Number 10f. Zip Coda 10g. Citizan of What Country? 9106 Pineview Lane 20735 U.S.A. 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilaga (1-4or 5+) Homemaker Own Home 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Hitte John Raley Mary I. 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat end Number or Rural Routa Number, City or Town, Stata, Zip Code) Janet T. Robertson/Daughter 1903 Elmwood Park Dr. Capitol Heights, Md. 20743 20b. Plece of Disposition (Neme of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from Stata 3/21/98 Washington, D. C. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 21. Signature of Funaral Sarvice Licenses 22. Name and Addrass of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 ak sed the deeth. Do not antar the mode of dying, such as cerdiac or raspiratory arres Immediate Ceusa (Final disaase or condition rasulting in deeth) a. Aspiration Prices
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Physician /Medical Examiner

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10a. Stata

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permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural" once.

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P.O. Box 68760.

Records.

Division of Vital

attending physician for use as the burie signed by the al certificate this After

þ Be Completed 27. Mennar of Daath

1 DNature

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

29b. Signature and title of certifie

Physician/Medical

Examiner

Certification: To

State Registrar

The law requires that the death certificate be executed To the Hospital or Attending Physician: filled in by the funeral within 24 hours after death. Medical

> 30. Name and eddrass of p 012 line 31. Data filed (Month, Day, Year) MAR 2.0 1998

5 Panding invastigation

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28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28e. Deta of Injury (Month, Day Year)

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28c. Injury at Work? 1 Yas 2 No

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2 Madical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) and manner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Straet end Number or Rural Routa Number, City or Town, Steta)

28d. Dascribe how injury occurred

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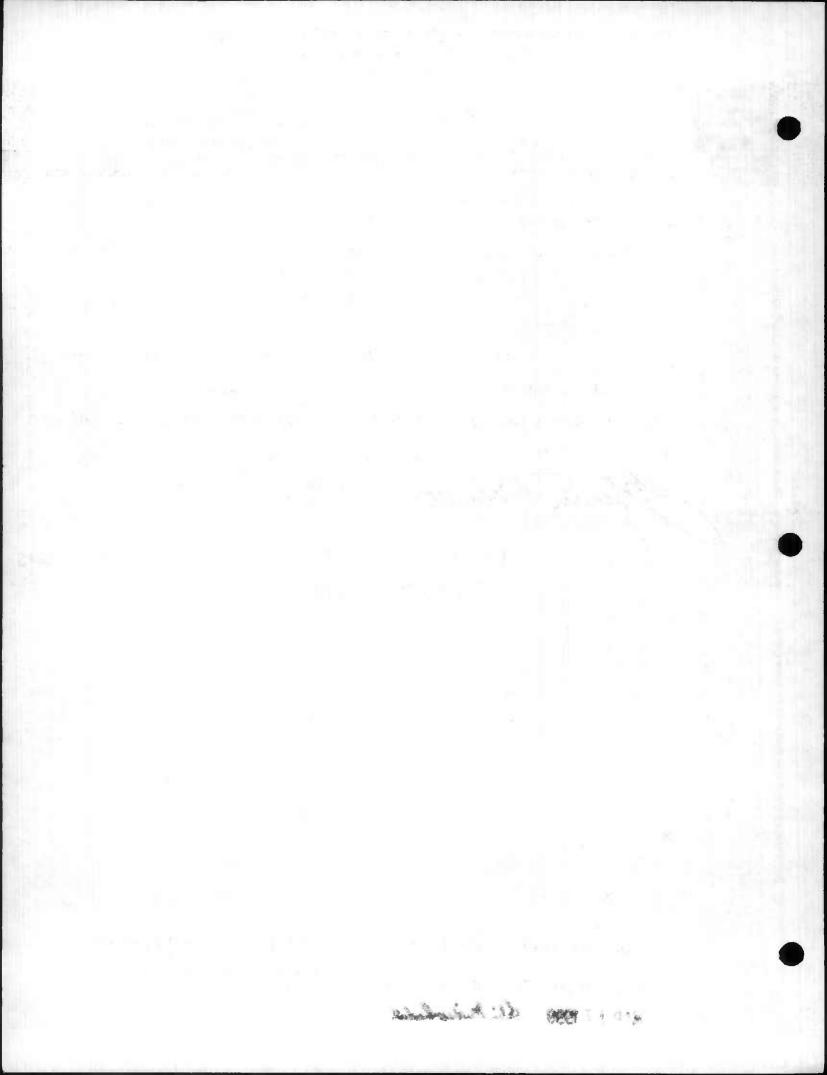
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death Month Yaar 13 98 10:30P.M.

Physician
/Medical
Examiner

4b. City, Town, or Location of Death

4c. County of Death P.G.

Birthplace (Stata or Foraign Country)

10d. Inaide City Limits

N☐ Yas 2 No

Alabama

10g. Citizen of What Country? U.S.A.

14. Rece - Amarican Indian, Biack, White, atc.

Specify: Black

16b. Kind of Business/Industry

Funeral

Director the Manyland "natural", or items 23a or 28a-f show

10a State MD 7602

Director by Funeral Completed Be

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours efter can of Heelth and Mantal Hygiene.
Int: If Item 27 is marked other than "natural", or item
Inty or other traumatic event, the Medical Examines.
Inty or other traumatic event, the Medical Examine.

Baltimore, Maryland 21215-0020

sician and burial-trensit The law requires that the death certificate be axecuted physician s the burial 88 USB ed by ate hes been signe page 2 should be certificate Hospital or Attending Physician: director. this funeral After

P.O. Box 68760.

Records,

Division of Vital

permit. Page Department of Important: If any Injury or Be Certification: To To the Hospital or Attending ithin 24 hours after deeth.
To the Funeral Director: After completely filled in by the fun

Examiner Physician/Medical by Completed Medical

11. Marital Status 1 ☐ Never Married 2 ☐X Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade complated) Elementary/Secondary (0-12) 17. Fether's Neme (First, Middla, Last) Charlie T. Smith 19a. informant's Name/Ralationship (Type, Print) Teresa 20a. Mathod of Disposition 1. Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 21 Signature of Funaral Sarvica Licansaa Immedieta Causa (Final disaasa or conditior rasulting in daath) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet Initieted avants rasulting In daath) Last

29a. Cartifiar

1. Decedant's Name (First, Middla, Last) Alfred Smith 03 4a. Fecility Neme (If not institution, giva street and number) Bowie Health Center Bowie 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Day, Yaar) Days Hours 1□M 2□ F Yrs 3/24/48 420-66-9396 49 Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location P.G. Landover 10e. Street and Number 10f. Zip Coda 20785 Ingrid Place 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☑ **N**o If Yas, Giva Year or Datas:

1 ☐ Yas 2 ☑ No Specify: 16a. Decedant's Usuai Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired)

Postal Worker

U.S. Post Office 18. Mothar's Nama (First, Middla, Maidan Sumame) Emma B. Wells

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 7602 Ingrid Pl.Landover, Md. 20785 20b. Placa of Disposition (Nama of camatary, cramatory or other place)

Harmony Cemetery 22. Nama and Addrass of Facility

20c. Location - City or Town, Stata 3/20,1998 Landover, Md.

Hodges and Edwards 3910 Silver Hill Rd. Suitland, Md. 20746 234 P.nt1. Entar the disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, book, or haart failura. List only ona causa on aech lina.

End Stage Renal Disease

Dua to (or as a consequanca of): Recurrent Aspiration Pneumonia

Dua to (or as a consequence of):

Dua to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellius

Collaga (1-4or 5+)

Smith

Ellura

24a. Was an eutopsy 1 Yas 2 No

1 Yss 2 No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

3 Probably 4 ☐ Unknown

23b. Did tobacco use contributs to the cause of death?

Approximate Intarval Batween Onset end Death

months

months

25. Wes casa rafarred to medical axeminer? 28. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 € ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify) 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred

5 Panding invastigation Natural 2 Accidant 1 Yas 2 No 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida

Location (Street and Number or Rural Route Number, City or Town, State)

1 CCartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Rakesh Aurora 31. Data filed (Month, Day, Year)

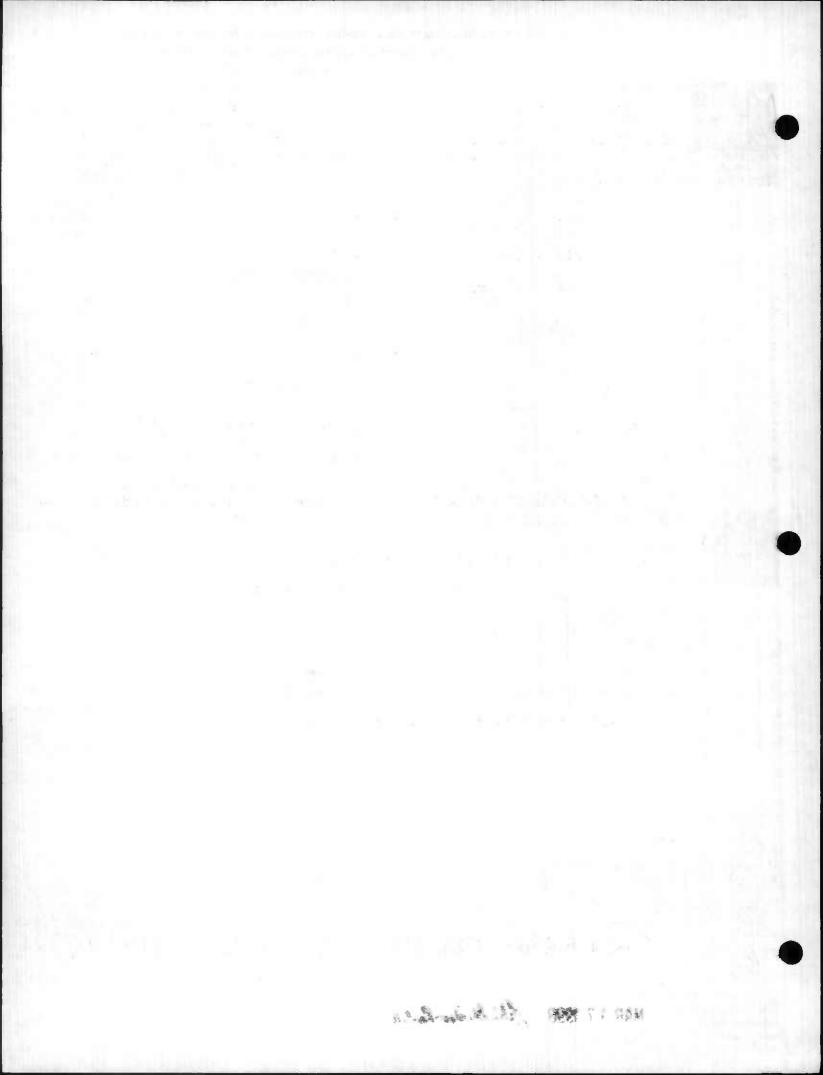
MAR 17 1998

Registrar's Signatura

14300 Gallant Fox Lane Suite 222 Bowie MD 20715

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Month Donald Joseph Seidenspinner March 14, 1998 /Medical 12:10 am 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert 5. Sociei Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 12 M 2□ F Days Yrs. Director 577-09-4516 81 Feb. 14, 1917 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show r than "natural", or lierns 23s or 28s-f shor the Medical Exeminer must be notified at 1 Yes 2 No Directo Maryland | Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13325 Dowell Road U.S.A. 20688 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩↓↓ 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hypisons. Insportant: If Item 27 is marked other than "natural", or her any injury or other traumetic event. 1 Never Married 2 N Married À 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administration 12 U.S. Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be George Frederick Seidenspinner Beatrice Lynch 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Pnnt) Alfrida A. Seidenspinner - Wife 269 Deer Drive, Lusby, Maryland 20657 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 3/18/98 Cheltenham, Maryland 22. Name and Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pah1. Enter the disease, or complications that caused the deal book, or heart failure. List only one cause on each line. Approximete Interval Betw **Physician** /Medical Immediate Cause (Finel PHEUMONIA disease or condition resulting in deeth) **Examiner** Due to (or as e consequence of): Examiner DEMENTIA The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician Physician/Medical the Due to (or as a consequenca of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? peed certificate has or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Natural 5 Pending s after dec. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and menner steted. 29e. Certifier Medical To the Hosp ithin 24 ho To the Fune (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 3/16/98 1)36969 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHENMO, 11910 H.G TRUEMAN RD LUSBY MD 20657

State Registrar 31. Dete filed (Month, Dey, Yeer)

32. Registrar's Signature

MAR 17 1998



21215-0020

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records.

What we will need to got to the

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** STEPHENSON LAURETTA 7:= 14 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHEVERLY PRINCE GEORGE GEORGE HOSPITAL CENTER 7. Aga (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month), Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sax **Funeral** 1 □ M 25 F 74 Yrs Director 240-32-9667 MAR-12-1924SEVERN, N.C. Usual Rasidance of Dacedent the Maryland 10a Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits rel', or items 23s or 28s-f shore Examiner must be notified at 1 Yas 2 No Director WASHINGTON, D.C. 10e. Street and Number 10g. Citizan of What Country? 20019 Funerai 4710- "C" S.E. #303 U.S. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, White, atc. Pages 1 and 2 should be filed within 72 hours efter of neat of Health and Mentel Hygiena.
Int. If fam 27 Is marked other than "naturel", or iter
Inty or other traumatic event, I'm Mentel. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas & No þ Specify: BLACK 3€Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) BERGMAN'S LAUNDRY LAUNDRY-WORKER 12th GRADE 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Sumema) Be JAKE BRANCH VIOLA WARREN BRANCH 19a. Informent's Nema/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 eny Injury or other troppe. 10109-DEVERE COURT, SILVER SPRING, MD. 20903 MICHAEL GLASCOE 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from Stata 3-20-98 BRENTWOOD, MD. FT.LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of FaciliMONTGOMERY BROTHERS F.H. 21. Signature of Funaral Sarvice Licansaa #879 23a. Part1. Enter the disease, or complications/that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 719-KENNEDY ST, N.W. WASH, D.C. 20011 Approximete Intarval Batween Onsat and Death **Physician** /Medicai Immediata Causa (Final disaasa or condition rasulting in deeth) SEPSIS wechs Examiner Due to (or es a consequence of): PNEUMONIA 2 wecks iding physician and isa as the buriel-transit or Attending Physicien: The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Diseese or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Coronary Artry Bypass Confr, Aortra and Mital Volve Dua to (or as a consequence of): Replacements P.O. Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yas 2 No 1 □ Yas 2 □ No certificate Division of Vital 25. Was casa referred to medical 28. Placa of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 →No this 27. Menner of Death Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred After 5 Panding Invastigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funersi Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowledga, daath occurred at the time, date and placa, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and mannar stated. Medical 29a. Cartifiar (Check only 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) Critical Core D52369 3-15-98 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) MANISH TANDON 3001 HOSPITAL DRIVE, CHEVERLY, MO 31. Data filad (Month, Day, Year) 32 Ragistrar's Signatura State MAR 18 1998 Registrar

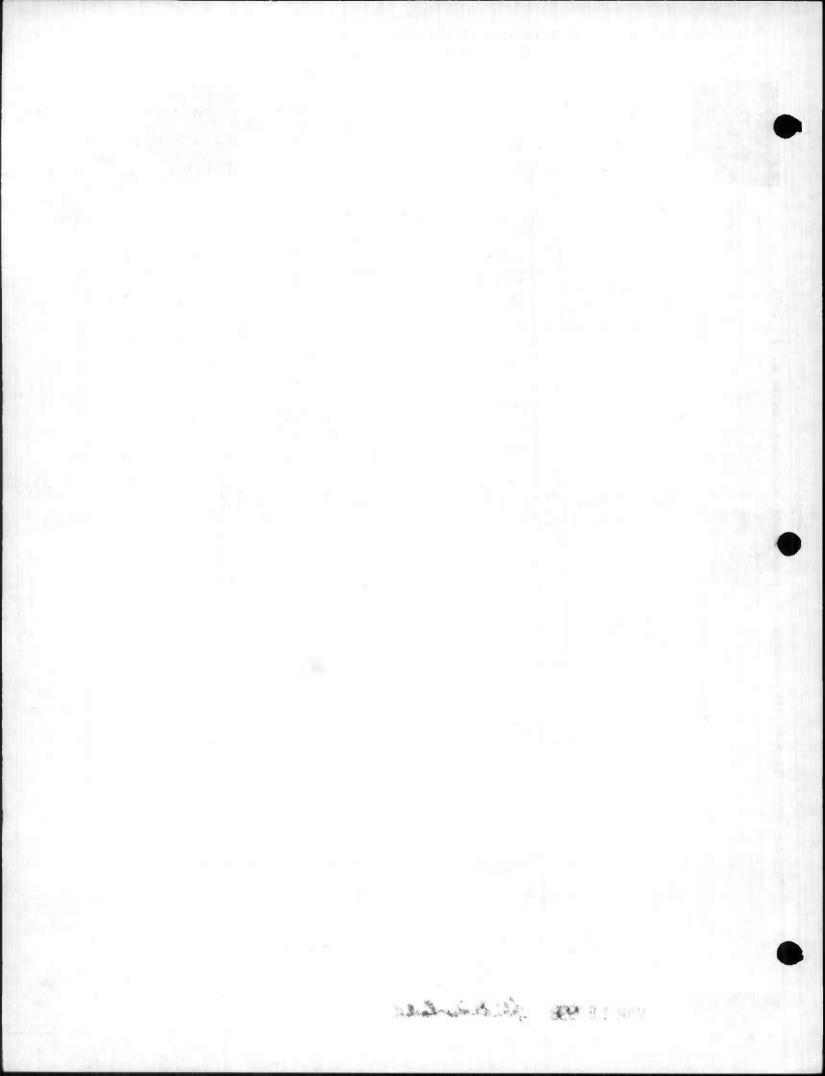
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Representative the

AND REPORTED

State of Maryland / Department of Health and Mental Hygiene

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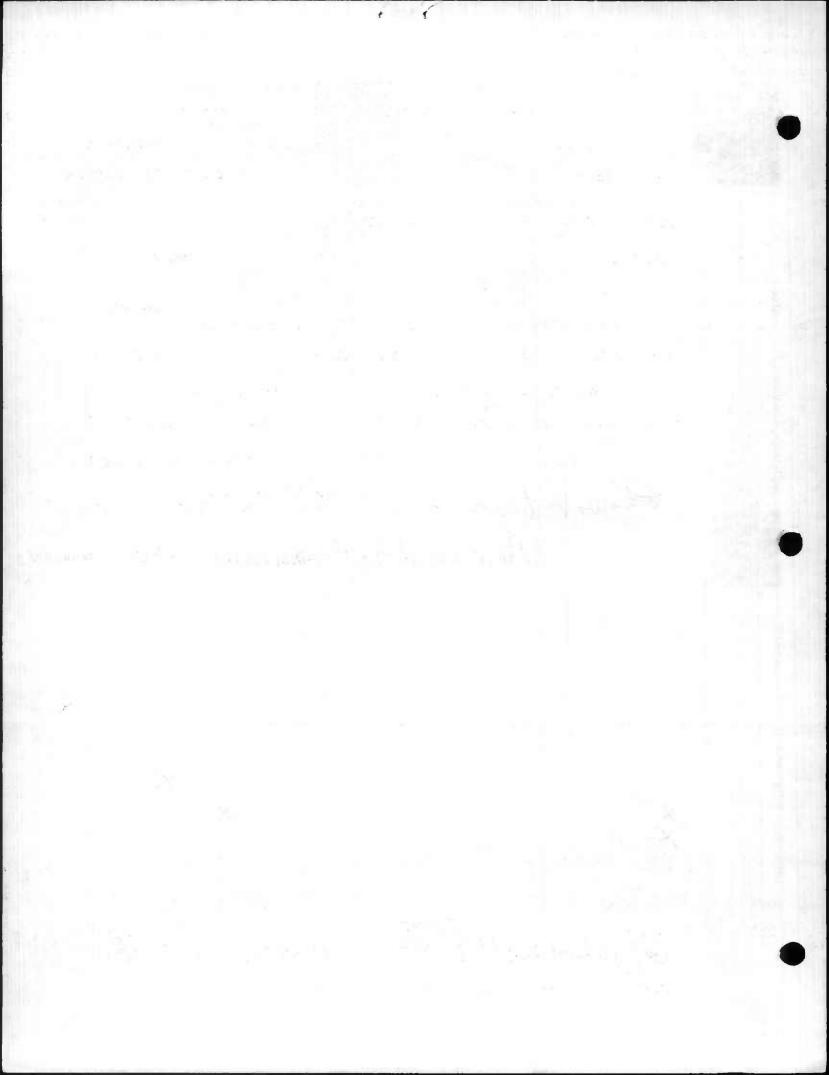
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Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629
31. Dete filed (Month, Day, Year)

AA 1 2 '98

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State Registrar



State of Maryland / Department of Health and Mental Hygiene

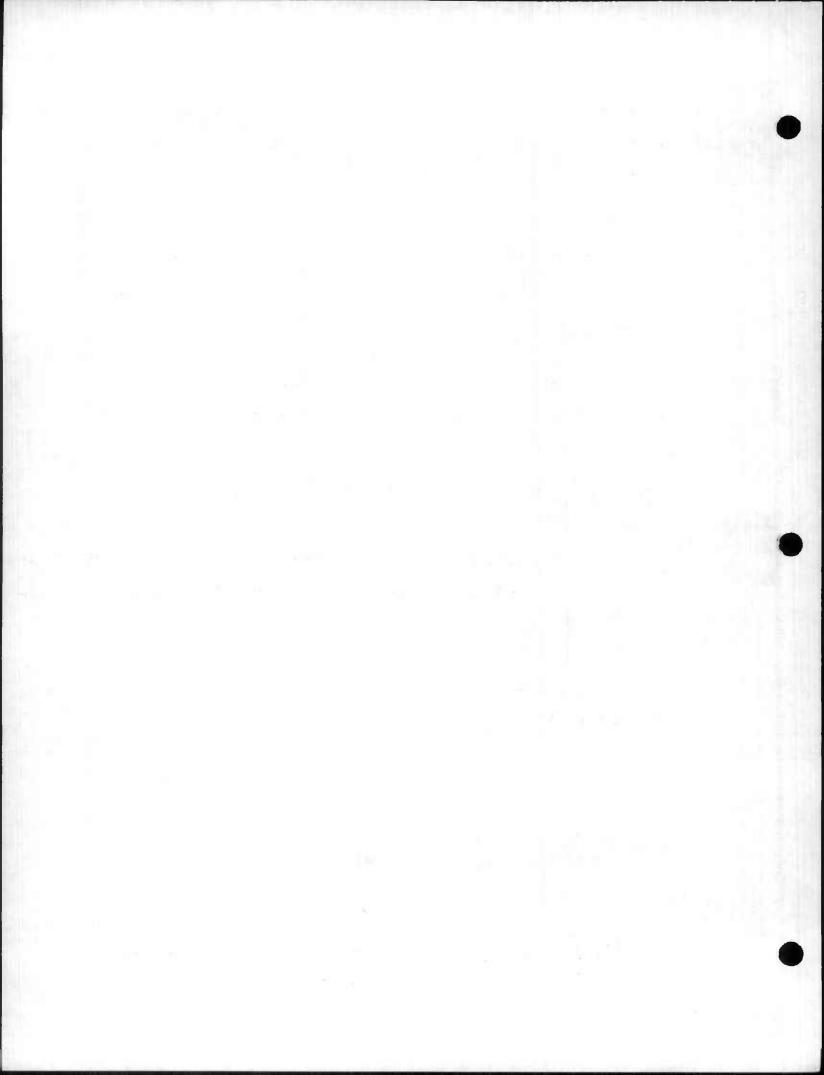
Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Month Vee Roy Edward Salyards 15 1998 9:06 p Mar. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Memorial Hospital Easton Talbot If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. XXM 2□ F 214-20-4528 Yrs Director Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow d 2 should be filed within 72 hours after death with the Marylar th and Mantai Hygiene.
7 is marked other than "natural", or itema 23a or 28af ahow traumatic event, the Med cal Examinal must be notified. Hurlock MD Dorchester AIXYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 45 Delaware Ave. #14 21643 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Di Yes 2 No If Yes, Give 46-49 Year or Dates: 1 Never Married MMarried white 1 ☐ Yes 2 No Specify: b 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Fork Lift Operator Amer. Standard Co. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Salyards Viola McMullen 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any Injury or other traconce. Donna Jean Salyards/spouse 45 Delaware Ave. \$14, Hurlock, MD 21643 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ©Buriai 2 ☐ Cremation 3 ☐ Removal from State Eastern Shore Vets. 3/19 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Due to (or as a consed Examiner with rapid rate or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai Due to (or as a consequence of): ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown þ should should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed has 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No death. after death 2 Accident in by the 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0052783 30. Neme and address of pers completed ceuse of death (Item 23e) (Type, Print) Cynthia Huffakes, M.D. 606 Dutchman's Lane, Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR18

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Registrar

SALYARDS

EDWARD

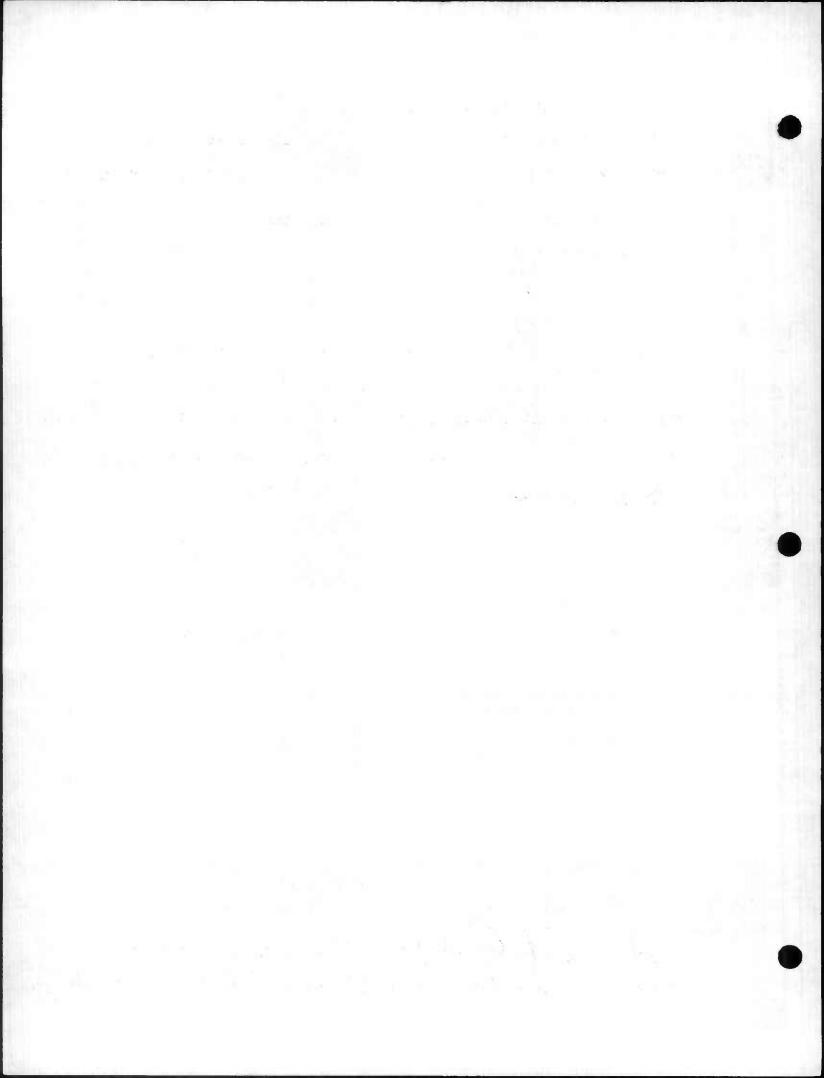


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** 1998 6, Vernon W. Stull, Jr. March 12:20 pm /Medicai 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28440 Bloomery Road Federalsburg Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 02/05/ 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days 1 JM 2□ F 76 215-12-8276 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐No Director Caroline Federalsburg MD 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 6 28440 Bloomery Road 21632 United States 238 Pagas 1 and 2 should be filed within 72 hours after death tant of Haalth and Mental Hyglene. Art: If Item 27 Is marked other than "naturel", or Itema 23 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1∑ Yes 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, etc.) Race - American Indian. Biack, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: '44 -'45 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Finance & Real Estate Of Baltimore City 18. Mother's Name (First, Middle, Maidan Surnama) 17. Father's Nama (First, Middle, Last) Be Vernon W. Stull, Sr. Ada Theil Stull Klaburner 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Haalth a: If item 27 is Helen Coale Stull/Spouse 28440 Bloomery Rd., Federalsburg, MD 21632 20b. Place of Disposition (Neme of cematary, cramatory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H important: If itea any injury or ott once. DE Buriai 2 ☐ Cramation 3 ☐ Ramoval from State Eastern Shore Veter. 3,9/98Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Framptom-Hawkins-Eskow Funeral 21. Signature of Funeral Service Licensee Esken PO Box 43, Federalsburg, MD 21632 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical immediete Cause (Finai weeks disaasa or condition resulting in daath) Examiner Examiner The law requires that the death certificate be axecuted attending physician and for usa as the burial-transit Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Division of Vital Records, P.O. Box 68760, sease Physician/Medical Due to (or as a consequence of) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of degth? 3 Probably 4 Donknown 1 Yes 2 No Ś 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? is cartificata has b 1 Yes 2 No 1 ☐ Yes 20 No the Hospital or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Plece of Daath (Check only one) 2 te No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) P 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28a. Dete of injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. tnjury at Work? Aftar 5 Pending investigation 1 Natural 1 Yes death. 2 Accident within 24 hours after death To the Funeral Director: , complately filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end manner es stated.

2 Medical Examinar: On the best of examination and/or investigetion, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. Medical 29e. Certifie (Check only one) 29b. Signature and title of certifian 29d. Data signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed ceuse of death (them 23h) (Type, Print) loomingdale Are Federalsburg MD 32 31. Date filed (Month Year) 32. Registrar's Signature State

ha Davidson

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death **Physician** Month TURNER Day RUTH Mar 11, 1998 3:00Pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Potomac Valley Nursing Home Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 6. Date of Birth 9. Birthplaca (State or Mary) 1905 Mary 1 and 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplaca (Stete or Foreign 1 M ZEXE Deys Hours 218-30-3878 93 Yrs. Director Usual Residence of Decedent with the Marylend 10a, State 10b. County 10c. City, Town or Location show 10d. fnside City Llmits r than "natural", or items 23a or 28a-f sho Director 1 XYes 2 No Dickerson Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20830 Peachtree Road 20842 U.S.A. Funeral 12. Was Decadent Ever In U.S. 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give filed within 72 hours effer 1 Never Married 2 Married 6 Maryland 21215-0020 1 ☐ Yes 2X No Specify: PV Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. Elementary/Secondary (0-12) 4th College (1-4or 5+) Domestic Home 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Menial Hy Important: If Nem 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Meiden Sumeme) Be Robert Marbley Matilda ? 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20871 Charles Harper (Executor) 12704 Running Brook Dr., Clarksburg, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Jerusalem Church Cem3/17/98 Poolesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Servica Licensee 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examine or Attending Physician: The law requires that the death certificate be executed and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that leited events.) TC VASCOLAR DISE Division of Vital Records, P.O. Box 68760, Physician/Medical thet Initiated events resulting in death) Lest Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? detached 1 Yes 20 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificete 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Seartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signeture aud # 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who compl (Item 23a) (Type, Print) Walter E. Goozh, M.D. 1299 Lamberton Dr., Silver Spring, MD 20902 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State ula Davidson Randalle Registrar MAR 16

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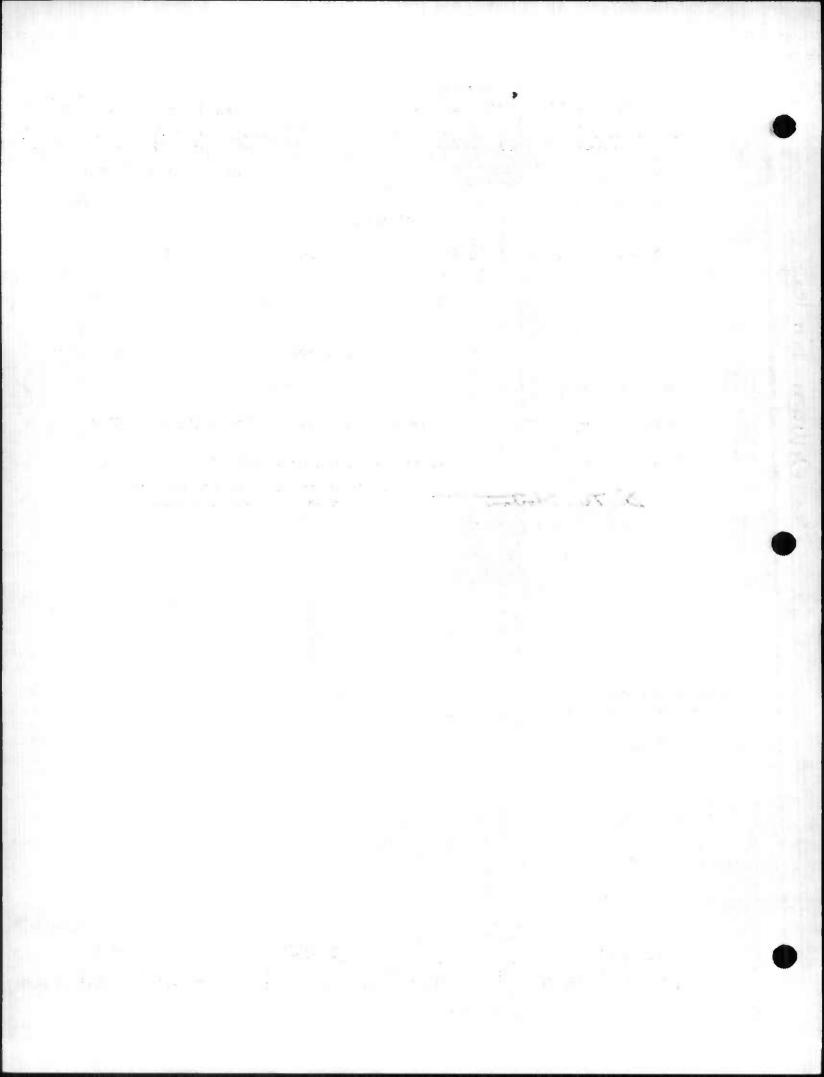
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3-17-98

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State of Maryland / Department of Health and Mental Hygiene

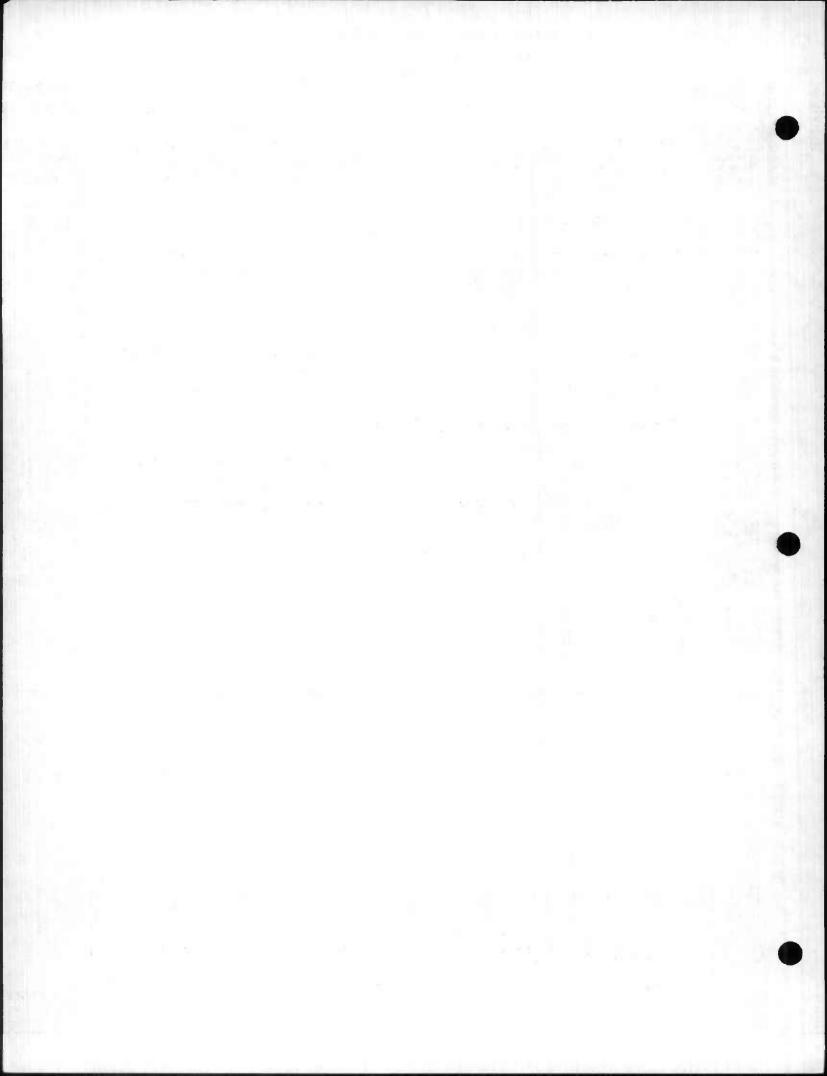
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68760,	ata b nysic	v/Medicai	that initieted events resulting in death) Las		C	Due	to (or as a cor	sequenca of):						1		
99	ng pl	Med	rooming in doubly and											1		
Box					d	-								Ī		
	0 0 0	Physician	Part II. Other significa	nt conditions	contributing to	death but not	t resulting in th	e underlying car	use giv	en in Pert I		23b. Di	d tobacco ua	contribute	to the ca	uae of death
P.0	that the ed by th detach	Phy										10	Yes 2 Xi	No 3□Pr	obably	4 Unknow
		by I								- 0						
Records,	requires been sign should be	Ped										24a. Wa	s an autopsy formed?		Vere auto	opsy findings prior to
20	- 00	plet										po.				n of cause
æ	0 - 6	Completed										10	Yas XX	No 1	Yes	2XXV0
ta			25. Wes case referred	to medical	1					26 Place	of Dea	th (Check only		1		
of Vital	Physician: this certific rai director,	25. Wes case referred to medical examiner? 1 Yes 2 No									Other (Spec	cify)				
0	a Physical Serain								c. Injun				e how injury o		,,	
io	ath. :: Afte	atio	1 K Natural 5 2 ☐ Accident	5 Pending investigation		nin, Day 198	ar) Inju	M		Yes 2	No					
Division	or Attending eftar death. Director: After 3 in by the fune	Hick	3 ☐ Suicida 4 ☐ Homicide	6 Could not be	288. Piec	e of Injury -	At home, farm	, street, factory,	office				(Street and N	lumber or Ru	ral Route	Number,
Ö	s eftar	Certification:	4 🗆 Horricide		build	ding, etc. (Sp	овсту)					City of 1	own, State)			
	popity houn mera y fille		29a. Certifier	Certifying Pl	ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital or Attending Ph within 24 hours eftar death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 one)	⊔ Medical Exa	miner: On the I	besis of exar nner stated.	minetion end/o	r Investigetion, I	n <i>m</i> y o	pinion, dea	th occur	rred at the time	e, dete and pla	ace, and due	to the ca	use(s)
	FEFE	Σ	29b. Signatura and title	o of contifier	TOTAL VA. U.S.		0	290	License	e number			29d. Date s	igned (Montl	Day Y	ear)
	5 ₹ 5 8	1 220				1 1	1	250.			rody D 38781				, ou, , ,	72.00
			> m	deed	1/	hod	9						March			
			30. Neme and address	char	completed cau	hod use of death	(item 23a) (Ty						March	16, 1		

Registrar

State

31. Date filed (Month, Day, Year)

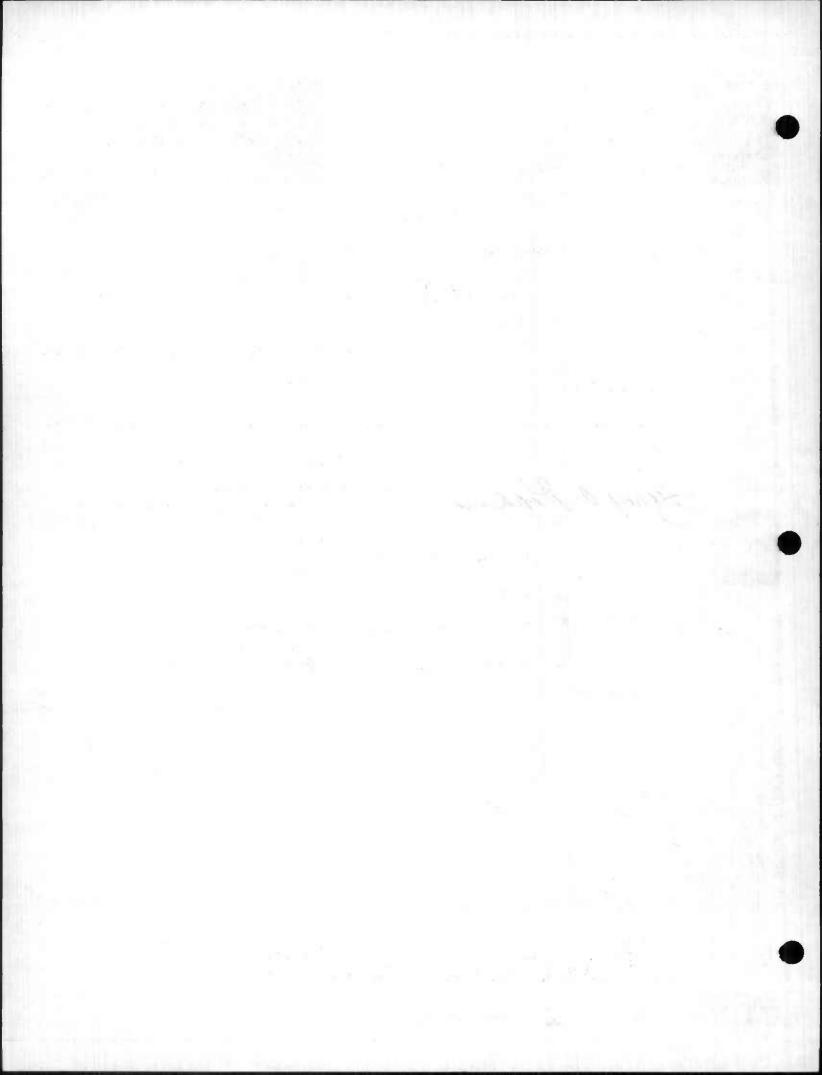
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					ar yraria		ificate of			Reg. No.		021	3
	Physici	ian	Decedent's Name (First, Middla, Le						2. Date of Dea Month	Day	Year		ot Death
	/Medi	cal	Maurice A. Tho					th Oh: Town or	Mar 17		10	04:0	01am
4	Examir	ner	4a. Facility Name (If not institution, given Holy Cross Hosp					Silver	Location of Death	4c. County			
_	uneral				e (in yrs. lasi	t birthday)	If Under 1 Year				_		e or Foreign
	irector		3/3-42-03/4	1ŪXM 2□ F	65	Yrs.	Months Days	Hours Min	8. Date of Birtl (Month, De) July 29	, 1932	Wash	ingto	on,DC
nylend	how		Usual Residence of Decedent 10e. State 10b. County			own or Loca					1		City Limits
® ₩	, i	cto	N/A N/A		Wash	ningto	n, D.C.					14🔼 Ye	es 2□No
h with th	23a or 20 at be no	Funeral Director	10e. Street end Number 4805 Arkansas Av	enue, N.W.			10f. Zip Code 20011			10g. Citizen of V United			
?1215-0020 within 72 hours efter death with the Menylend	important; if them 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exercicet must be notified at once.	by	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Xes 2 1 If Yes, Giva Year or Dates:1	No I / / / -))	as Decedent of H Yas, specify Cub	fispanic Origin? (S an, Mexican, Puer Specify:	Specify Yas or No- to Rican, etc.)		e - Americ ck, White, :: Bla	etc.	
Maryland 21215-0020 nd 2 should be filed within 72 hours ef	a Medical	Completed	15. Decedent's E (Specify only highast gri Elementery/Secondery (0-12)	ducation eda completed) College (1-4or 5	5+)	(Give ki	O NOT use retire	during most of wo d)		16b. Kind of Bu			
D 200	1,1		17 Fether's Name /First Middle se	12 Food & Drug Adminstration Fethar's Nama (First, Middle, Last) 18. Mother's Name (Fi								erner	nent
and be f	0 pe o	Be C	Andrew M. Thomas					Ella E		Meideri Surrietti	ia <i>)</i>		
shouf	E E	2	19a. Intormant's Name/Reletionship	_		19b. Meiling	Address (Street		urel Route Numbe	r, City or Town,	Stete, Zip	Code)	
M Spin	27 is r tra		Angela T. Garcia	(daughter)) 4	4805 A	rkansas	Ave. N.	W., Wash	ington,	D.C.	200	011
Baltimore,	or oth	20a. Method of Disposition 1						1	Date	20c. Location -			
it. P	Injury		21. Signature of Funeral Service Lice		нагто		MOTIAL Name and Addre		3/21/98	Landove	r, Ma	ryla	nd
D S	any Ir	-	Henry A.	92,	-)	Mc	Guire F	uneraĺ S	ervice,		_		20012
68 / 50, ificete be axecuted	Physician Medical Examiner st the principles Control	n/Medical Examiner	Immediate Cause (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events rasulting in death) Last	.645	Due to (or as Due to (or as Due to (or as	s a conseque	FAILUM ence of):	re 1 Pt	es Myeb	MA.		Onsat an	
the death	ed by the attanding detached for use as	Physician/M	Pert ii. Other significant conditions of	ontributing to death be	ut not resultin	g in the und	erlying cause giv	ven in Part I.	23b. Did to	obacco use co	ntributa to	the caus	e of death?
S, F.	5 8	by Ph							1 U Y	res 2□ No	3 Prol	pably 4	Unknown
I RECORDS, P.O. BOX The law requires that the death cert	s been s 2 should	Completed							24a. Wes e perfor	en eutopsy med?	CO	ere autops elleble prio mpletion o death?	or to
	e e	S							1 □ Y	es 2 No	1 0	Yes 2	□ No
VICION: T	ils certificate I director, paç	Be	25. Wes case reterred to medical examiner?	Hospital:			011		ath (Check only or	ne)			
o hys	O O	은	1 Yes 2 No 27. Menner of Death	Inpatia		/Outpatient	3□ DOA Oth	4 U Nursing I	Home 5 Resid			v)	
DIVISION OF VICE for Attending Physician: after death.	Director: After thi I in by the funeral	cation	1 Natural 5 Pending Investigatio		y Year)	b. Time ot Injury	M 28c. Injur Wor	yet k? Yes 2□No	28d. Describe h	ow injury occur	red		
To the Hospital or Att within 24 hours after d	rai Direct	Certification:	3 Suicide 6 Could not be determined	building, etc	c. (Specify)				28t. Location (S City or Tow	n, Stete)			um <i>ber</i> ,
• Hosp	To the Funeral Dir	edicai	29a. Certifier (Check only one) 12 Certifying Ph 2 Medical Exer	ysictan: To the best on ninar: On the basis of end menner ste	examination	dge, death o and/or inve	stigation, in my o	ne, dete end place pinion, deeth occ	e, end due to the d urred at the time, d	euse(s) end ma dete end place,	and due to	the cause	e(s)
To the	Toth	Me	29b. Signeture and title of certifier	11.			29c. Licans	e number	2	29d. Date signe		Contract Contract)
6			Hay	M			D	5219	1	Mar 17	,199	8	
٦			30. Name end address of pelso who Estaban Marquez	completed ceuse of d MD 1500 F	eath (Item 23 orest	Glen	Rd Silve	er Spring	g Md 2091	.0			
	Sta	ite	31. Dete filed (Month, Day, Year)		er's Signature	-							

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama /First Middle Last 2. Data of Death 3. Tima of Death Bobby Thomas 11:49 PM March 15, 1998 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street and number) 4c. County of Deeth Takoma Park Washington Adventist Hospital Montgomery | File | House | Hours | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House | House 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax Birthplace (Stete or Foreign Country) 10XM 20 F 23 Yrs. 1974 Maryland 215-96-8394 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20783 2211 Apache Street USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑No If Yas, Giva Yaer or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Bace - American Indian Bleck, White, etc. 1 X Never Married 2 Married 1 Yas 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Student Education 18 Mothar's Nama (First Middle Maiden Surname) 17. Father's Neme (First, Middla, Last) Thomas P. Jackson Leelamma Joseph 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informent's Name/Ralationship (Type, Print) 20783 Thomas P. Jackson (father) 2211 Apache Street, Adelphi, MD 3/19/98 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBurlai 2 ☐ Cramation 3 ☐ Ramovei from Stata George Washington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 21. Signature of Funaral Servica Licensee Francis J. Collins Funeral 22. Nama and Addrass of Facility 500 University Blvd. West Home, Inc. Drone Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Daeth Immediata Causa (Final Respiratory Arrest Dua to (or as a consequence of): Obstruction Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquanca of): Congenital Deformitus Dua to (or as a consequence of)

Physician /Medical Examiner

physician and the burial-transit

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10a. Stata

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7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Mosical Examiner must be nothfied at

pemit. Pages 1 end 2 should be filed within 72 hours effer death v Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mental

Baltimore, Maryland 21215-0020

the Manyland

Retarded Development

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the causa of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performad?

24b. Wera autopsy findings available prior to complation of causa of death?

1 ☐ Yas 2 ♣ No

1 ☐ Yas 2 ☑ No

25. Was casa rafarrad to madical axaminar? 1 Yas 2 No

disaasa or condition rasulting in daath)

Hospital: 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28c. Injury at Work?

28d. Dascribe how injury occurred

1 ☐ Yas 2 ☐ No 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)

27. Mannar of Death

2 Accidant

4 [] Homicida

3 Suicide

1 DeNatural

1 🔀 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of cartifian

5 Panding

Invastigation

6 Could not be datarmined

29c. Licanse number D19935

29d. Data signed (Month, Day, Year)

198 6

30. Nama and addrass of person who complated causa of daath (item 23a) (Type, Print)

Samuel L. Deshay, M.D. 7610 Carroll Avenue, Takoma Park, MD

State Registrar 31. Data filad (Month, Day, Year) 18 MAR

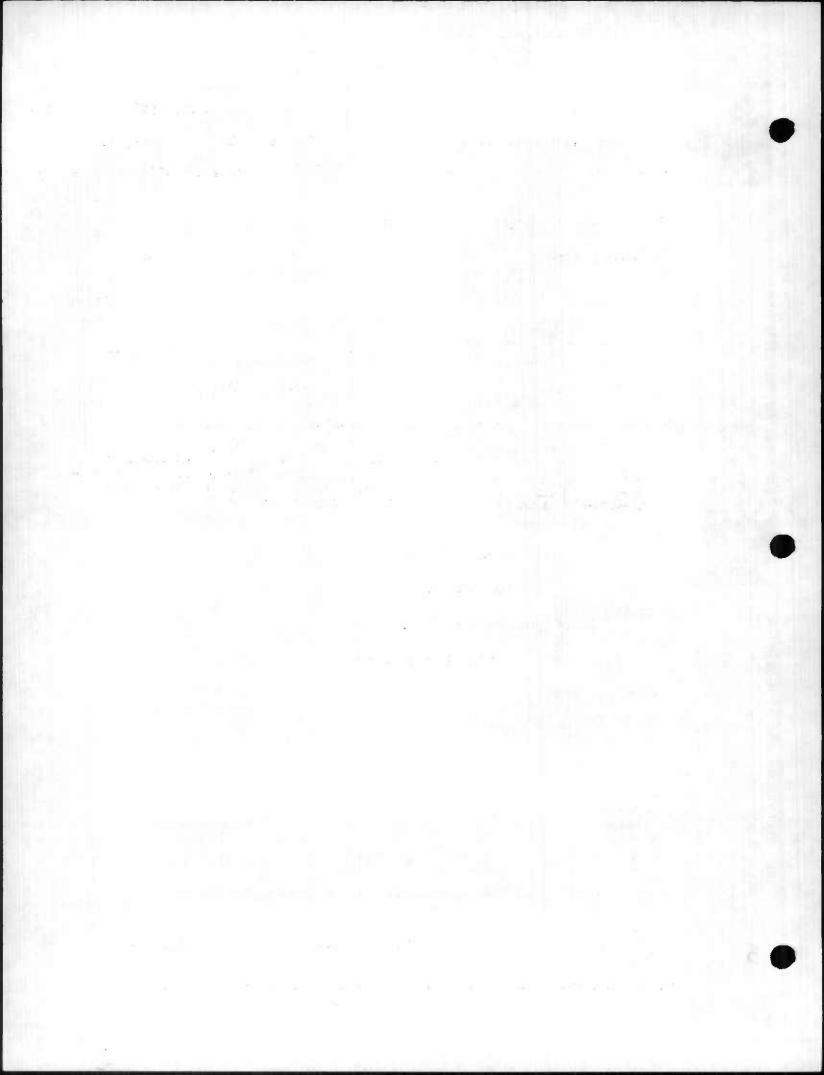


DHMH 16 Rev 6/95

Box 68760 P.O. Division of Vital Records,

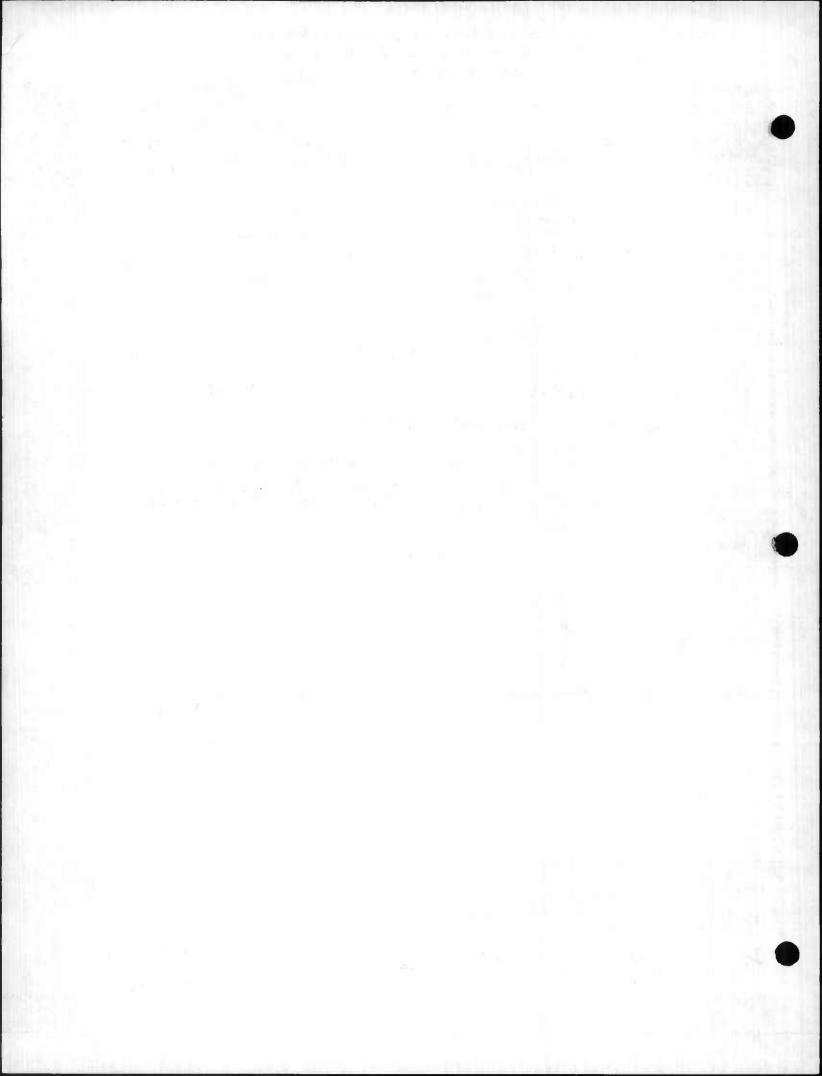
The lew requires that the death certificate be executed

or Attending Physician: after death. 24 hours after deatlerer: Hospital To the I within 2 To the 8



State of Maryland / Department of Health and Mental Hygiene

						C	erti	ificate of	Death	7		Reg. N	lo.	1	06)
	Stt.		1. Decedent's Name (First, Middle, La	ist)			21				2. Dete of D	eeth		Vaar	3. Tim	e of Death
	Physic /Medi		Re	enee	Tahar	n					Month		^{ay} 199	8 Yeer	6:0	00 PM
	Exami		4a. Fecility Neme (If not institution, gir	re street end nu					4b. City, To	own, or I	Location of Dee	-		of Deeth		
			6112 Clearwood F	Road					Bethe	sda		М	lon t.a	omer	/	
1	Funeral			Sex	7. Age (In yi	rs. lest birtha		If Under 1 Year	If Under	24 Hrs.	8. Date of B	irth				te or Foreign
	Director		579-92-6129	1□ M XXF	86	Yrs	s. '	Months Days	Hours	Min.	March 2	6. T	911	Cou	ntry) Ec	ypt
	D		Usual Residence of Decedent													,,,
	whow I		10a. State 10b. County		10c.	City, Town o	r Loca	tion								e City Limits
	a-f.s	cto	Maryland Montgom	ery	Ве	thesda	1								10	res 2 XNo
	# 28	Director	10e. Street and Number					10f. Zip Code				10g. C	itizen of \	What Cou	ntry?	
	h wil		6112 Clearwood R	oad				20817				Un	ited	Sta	tes	
	within 72 hours after deeth with the Maryland ane. than "natural", or items 23a or 28a-f show he Modical Examinet must be notified at	Funeral	11. Marital Stetus		edent Ever In	U,S.	13. Wa	s Decedent of	Hispenic Or	igin? (S	pecify Yes or N		14. Rac	e - Ameri	en fndia	١,
0	or its		1 Never Married 2 Married	Armed F	2V No			es, specify Cub			o Hican, etc.)			ck, White,	etc.	
Maryland 21215-0020	d within 72 hours af piene. r than "natural", or the Medical Exam	b	3 Widowed 4 Divorced	If Yes, Gi Year or I	Dates:		1 L]Yes 2☐XNo	Specify	:			Specify	γ:	Whit	e
2-0	72 hours "natural",	ted	15. Decedent's E	ducation		16a. De	eceder	nt's Usual Occu	pation		dela a	16b. I	Kind of B	usinass/In	dustry	
2	thin .	Pg.	(Specify only highest grant Elamentary/Secondary (0-12)		1-4or 5+)	lif	fa. DO	nd of work done NOT use retire	ed)	St OF WOR	King					
21	77 70 10 10 10 10 10 10 10 10 10 10 10 10 10	5	15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during m lifa. DO NOT use retired) Homemaker									0wn	Hom	е		
D	be filed hel Hygie d other event, tr	Be (17. Father's Name (First, Middle, Last)					18. Moth	er's Nan	ne (First, Middle	e, Maide	n Sumen	10)		
la	should b nd Mente marked	To	Alexander Moghr	aby					Mari	е	Shihata					
an	and his ma		19a. Informant's Name/Relationship (Type, Print)		19b. M	lailing .	Addrass (Strea	t and Numb	er or Ru	rel Route Num	ber, City	or Town,	Stete, Zip	Coda)	
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Nevine Gargour	(daug	hter)	Sa	ame	as 10								
ore	es 1 end of Health I item 27 r other tr		20a. Method of Disposition			. Place of Di	ispositi	ion (Neme of tory or other pla	ice)		Date	20c. L	ocation -	City or To	own, State	9
E	Pages nent of nrt: If its iry or o		1 ☐XBuriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Stete			aven Ce	-	v :	8-18-98	Silv	er S	Sprin	a. M	arvlan
altimore,	- 논란은		21. Signature of Funeral Service Lice	nsee	0			lame and Addro						F	3,	J
Ö	Depa impo any i		1 2000 x L	1 /	200		Kap	p Funer	al Se	rvic	es, P.	A.	00 1	4D 20	010	
			23a, Part1. Enter the disease, or com-	piicetions that	caused the de	eath. Do not		3 Gist					ig, i	ער בט	Approxi	mate
	et violen		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on	each line.					00.0.00	or raspiratory	ai rao (Interval	Batween nd Deeth
	Physician /Medical		fmmediate Cause (Final													
	Examiner		disease or condition rasulting in death)	e. Pan	creati	c Cano	cer							8	mon	tns
		-			Due to	(or as e con	sequ <i>e</i>	nce of):								
	nsit	Examiner		b				,								
	si-tra	xar	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying		Due to	(or as a con	iseque	nce of):								
9	be e	alE	cause. Enter Underlying Cause (Disease or Injury that initiated events	C										į		
68760,	eath certificate be executed attending physician end for use es the burist-transit	edical	resulting in death) Last		Due to	(or as a con	seque	nca of):						i		
×	certif ding se e	Σ		d												
Box	death e atter	Physician														
o.	thet the death ned by the atter deteched for u	ysi	Pert II. Other significant conditions of	ontributing to d	eath but not r	esulting in th	e unde	erlying ceusa gi	ven in Pert	I.	23b. Dfc	tobacc	o uaa co	ntributa t	the ceu	se of death?
Δ.	es thet ligned by										1	Y00	2 No	3 ☐ Pro	bably	I 🗌 Unknown
ds	8 60	d by									24a. Wa	000 0111	20011	24h W	ere autor	sy findings
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3ec	2 8	Completed				_									déath?	
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of Vital Records,	Physician: The tribs certificate and director, pag	Be	25. Was cese rafarred to medicei examiner?	100000				11121		a of Dea	th (Check only	ona)				
5	200	2	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpa	tiant	3□ DOA Ot	her: 4□ N	ursing H	ome 5 Res	idence	6 □Oth	er (Specil	(y)	
ם	fter t	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Panding	28e. Date (Mon	of Injury oth, Dey Year)	28b. Tim fnju		28c. inju Wo	ry at ork?		28d. Describe	how Inju	ury occur	red		
Division	Attending or death.	Certification:	2 ☐ Accident investigatio					M 1]Yes 2□	No						
ž	or Attendence Directed in by t	¥ E	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicida datarminad	280. Place	of fnjury - Ating, etc. (Spa	homa, farm,	street	t, factory, office			28f. Location City or To			er or Rure	al Route I	lumber,
	rs affor				3 (-,											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Cartifiar 1 CertifyIng Ph (Check only 2 Madical Exar	ysician: To the	best of my ki	nowiedga, da	aath o	ccurred at tha ti	ima, date ar	nd piace	, end due to the	ceusa(s	s) end me	ennar es s	teted.	20/2)
	the H in 24 the F	pe	one)	and man	ner stated.	nation and	IIIVGG	inganon, in my	opinion, das	XIII OCCU	ired at tila tilla	, Gata ai	id piace,	and dua (J tila Ceu	10(3)
	To the Within 2 To the comple	Σ	29b. Signeture and allowed munifier	5)			29c. Licen	se number			29d. D	ete signe	d (Month,	Dey, Yes	r)
	2-		(Same	4	/			D 17	935			Marc	h 16	, 19	98	
			30. Name and address of person who	completed caus	se of death (It	em 23a) (T y	e, Pri	nt)						., .,		
			Sands K. Irani,	M. D.,	5530	Wisco	nsi	in Avenu	ue, #9	914.	Chevy	Chas	se, M	D 20	815	
	Sta	te	31. Date filed (Month, Day, Year)	32. F	egistrer's Sig	nature						_			- 	
	Registr	ar	MAR 16 19	98 9	ha Davi	door-10	nde	20								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate (of L	Death			Reg. No				
			Decedent's Neme (First, Middle	e, Last)								2. Dete of De	eth			3. Time	of Death
	Physic		j	JOHN PETER	RTEI	LLER						Month MAR	B Day	1998	eer	3.1	55 AM
	/Medi Exami		4e. Fecility Neme (If not institution						41	b. City, To	wn, or Lo	ocation of Deet	-	County of	Deeth	٥.,) An
	CAdilli	iei	the street street and the street of			CENTE	D						1.0				
	_	_	5. Sociei Security Number	NAVAL MED		I CENTE		If Under 1 Y	eer	If Under	ETHE	SDA 8. Dete of Bir	th.		VTGO		
	Funeral		131-30-2038	10XM 2□ F	50		Yrs.		Bys	Hours		(Month, De	Year)	120	Countr	y) Por	or Foreign t Jer
	Director		Usuel Residence of Decedent			,						Whili 1	.0,15	30 Ne	ew Yo	ork	
	and a		10e. State 10b. County		1	10c. City, Town	or Loc	ation							10	d Inside (City Limits
	a P	5	- 371 111			m.1.2											s 2 No
	2 2	Director	Jersey Middl	esex		Edi	son							11.00			
1	8		10e. Street end Number					10f. Zip Cod						ted S			
į	be incompined a routs enter death with the maryland till Hyglene. d other than "natural", or items 23a or 28e-f show event, the Modifiel Exactines must be notified at	Funeral	16 Adelphi Cour					088					of	Amen	cica		
		une	11. Maritel Stetus	12. Was Dec	edent Ev rces?	er in U,S.	13. W	as Decedent Yes, spacify (of His	spenic Ori n, Mexicer	gin? (Sp.	ecify Yes or No Ricen, etc.)	-	14. Race - Bieck.	America White, et		
20	8		1 Never Married 2 Marr	ied 1 X Yes If Yes, Gi	2 No	962-		□Yes 2K0		Specify:				Specify:			
ò	in in	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:	962- 1982								ореспу.	Whi	te	
2	natin of the	Completed	15. Deceden (Specify only higher	t's Educetion		16a.	Decede	ent's Usuel Oc	ccupe	tion uring mos	t of work	ina	16b. Ki	ind of Busin	ness/Indu	ustry	
Maryland 21215-0020	Hyglene. ther than "	n d	Elementery/Secondery (0-12)	Coilege (I-4or 5+)		life. D	and of work do	tired)			9	Uni	ted S	State	es	
7	Hyglene. other than	Son		4		Li	eute	enant (Con	mand	er			Navy			
ם פ	£ 4 5	Be	17. Fether's Name (First, Middle,	Last)						18. Mothe	r's Name	e (First, Middle	Maiden	Sumeme)			
<u>a</u>		10	John J. Teller							Luc	y Tr	opeano					
ar,			19e. Informent's Neme/Reletions	hip (Type, Print)		19b	Meiling	Address (St	reet e	nd Numbe	or or Run	el Route Numb	er, City o	r Town, Ste	ete, Zip C	Code)	
	47		Lucy Teller / Mo	ther		48	Clo	ove Roa	ad.	Mon	tagu	e, New	Jers	ev 07	7827		
ē,	9 5 5		20e. Method of Disposition					sition (Neme o				Dete	20c. Lo	cation - Cit	v or Tow	m, Stete	
altimore,			N Buriai 2 ☐ Cremetion		State	Coint	y, crem Mass	etory or other y 's Cer	plece	9)		larch	Por	t Jer	vis,	,	
	rtan		4 Donetion 5 Other (S)		2600	Sallic						2, 1998	New	York	(
Ba	Department of important: If any injury or sales.		21. Signet re of Funerel Service	Licensee # MUI	0690			Name end Ac				Home				127	71-072
	10.2 0 0		Loware	May	De	~						et, Por	t Je	rvis,	New		
			23a. P. 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	eused th	e deeth. Do r	ot ente	r the mode of	dylng	, such es	cerdiac	or respiretory e	rrest,		1	Approxime	ete etween
P	hysician														(Onset end	Death
	/Medical		Immediate Ceuse (Final disease or condition		A C	CVD	(A:	rterio	201	orot	io C	ardiova	1		1		
E	xaminer		resulting in deeth)	е		ue to (or es e			SCI		isea		scul	ar	1		-
		Je								Δ.	Loca	50)					
9	d d ensi	Examiner	Sequentially list conditions	b	Di	ue to (or es e d	onsequ	ience of).									
,	ial-tr	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter linderlying		00	30 (0 (0) 63 6 (onsoqu	ionos orj.									
09/89	sicia	ca	ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events	C	Du	10.10./07.00.0									-		
ox b&/bU,	ding physician and ise es the burial-trensit	/Medical	resulting In deeth) Lest		Du	e to (or es e c	onsequ	ence or):							1		
XO	nding			d							_						
ď	etten for u	Physician															
j 3	igned by the ette	ys	Pert II. Other significant condition	ns contributing to de	eath but	not resulting in	the un	derlying ceuse	give	n In Pert i		23b. Did	tobacco	usa contri	buta to t	the cause	of death?
7 5	deta											1 🗆	Yes 2	□ No 3	☐ Probe	bly M	Unknown
VITAL Mecords, P.O. Bo	sign 1 be	1 by											_		146 141		41- 41
10	peen si	Completed										24e. Wes	en eutop	osy 2	eveil	e eutopsy leble prior	to
O I	98 b	pldr													of de	pletion of seth?	ouse
<u> </u>	ate h	ő										X	Yes 2	□No	1 🗆	Yes 2X] No
		Bec	25. Wes case referred to medical							26. Plece	of Deeti	h (Check only			-		
	is cert direct	0	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient	2□ ER/Ou	petient	3□ DOA	Othe	r: 4□ Nu	rsina Ho	me 5 Resi	dence (6 □Other	(Specify)		
0 4	eral d	Ë	27. Manner of Deeth	28e. Dete	of Injury	28b. T	ime of	28c.	Injury			28d. Describe					
	After funer	it lo	1 Neturel 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Y	'ear) II	njury			es 2 🗆	No						
S	ctor th	fice	3 ☐ Sulcide 6 ☐ Could r		of Injury	- At home, fe	m, stre	et, factory, off	ice			28f. Location (Street en	d Number	or Rurel I	Route Nu	mber,
DIVISION	Dire	Certification:	4 Homicide	buildi	ng, etc. ((Specify)		,,				City or To	wn, Stete)			
-	eral fille		29e. Certifier 1X Certifyin	g Physician: To the	boet of r	ny knowlodao	dooth	anguired at th	o tim	o date on	d place	and due to the	ooueo(e)	and mann	or ac clai	lad	
, H	Fun Fun	edical		Examinar: On the ba	asis of ex	caminetion end	Vor inve	estigetion, in n	ny op	Inion, dee	th occurr	ed et the lime,	date end	place, end	due to t	he cause	(s)
4	within 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral	Mec		end men	101 \$[2]0	u.		200 110	anec	number			20d Des	te signed (F	Month D	av Veer	
٤	¥ 5 8									3 mm h		23u. Dai	o signed (r	6	of, (00/)		
			ranks	Kan	N	10		19	943	74-1	NY)		3	191	18		
			30. Neme and eddress of person	who completed caus	e of deer	th (Item 23e) (Type, P	rint)			NAT	IONAL N	IAVAT	MED	ICAL	CENT	ER
			PAUL D. KANE	L, LCDR, M	C, U	ISN						HESDA N					
	Sta		31. Dete filed (Month, Day, Yeer)	0 1000 32. R	egistrar's	Signature	40										
	Registr	ar	MAR 1	2 1998	gun	a Davidso	1-1/0	madelle									

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	OIAIL OI I	CE		ICATE OF				EG. NO			
	1. DECEDENT'S NAME (First, Middle, Li	ist)						2. DATE OF D	EATH			3. TIME OF DEATH
	MOLLIE S. TEV	/IS						MARCH	14.		YEAR	2:50 A.M. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER 1 YEAR	IF UNDE	1 24 HRS.	7. DATE OF 8	HTH		a. BIRTH	PLACE (State or Foreign
	579-32-2070	1 🗌 M 2 🔯 F	91	YRS.	MONTHS DAYS	HOURS	MIN.	(Month, Day		1906	DENIN	SYLVANIA
	9e. FACILITY NAME (If not institution, g.	ive street and number)			9b. CITY, TOWN	OR LOCATI			/ 9]		NTY OF D	
DIRECTOR	SOUTHERN MARYLA	ND HOSPITA	AL		CLINTO			4				GEORGE'S
EC	10e. STATE 10b. COL			10c, CI1	TY, TOWN OR LOCA	TION						10d. INSIDE CITY
HO	MARYLAND PRI	NCE GEORGI	E†S	l c	LINTON							LIMITS? 1 YES 2 X NO
	10e. STREET AND NUMBER			0.		of, ZIP COD	E			10g. CITI	ZEN OF V	VHAT COUNTRY?
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FUNERAL	11. MARITAL STATUS		NT EVER IN U.S. AR			CENOENT	OF HISPAI	NIC ORIGIN? (Sp			14. RACE	- American Indian,
BY FI	1 Never Married 2 Married 3 X Widowed 4 Divorced		1 ☐ YES 2 🔀 N WAR OR DATES	10		pecify Cub- S 2 X NO		in, Puerto Ricen y:	, etc.)		Speci	WHITE
ED	15. OECEOENT'S		16a, OE	CEDENT'S	USUAL OCCUPAT	ION		16b. KINI	D OF BU	SINESS/IND	DUSTRY	-
ETI	(Specify only highest g Elementery/Secondery (0-12)	College (1-4 or 5	- Hite	Do NOT u	work done during make retired.)	ost of work	ng					
PL	12			1EMAI	KER			OWN	IED I	HOME		
COMPLET	17. FATHER'S NAME (First, Middle, Last,					18. MOT	HER'S NA	ME (First, Middle	, Meiden	Sumeme)		
	MICHAEL ZELDER					MO	LLIE	MILLER	2			
BE	19a. INFORMANT'S NAME (Type/Print)		198	. MAILIN	3 ADDRESS (Street					n, Stete, Zig	Code)	
10	LOWELL D. TEVIS	, SON	42	214 (COLUMBIA	PARI	K RO	AD. POM	FRE'	т. мг	206	575
	20e, METHOD OF DISPOSITION		20b. PLACE	AND DATE	OF DISPOSITION //	lame of		DATE		CATION —		
	1 Buriel 2 K Cremetion 3 1 1 4 Donetion 5 Other (Specify)	temoval from State	cemetery, cre FORT L	INCC	OLN CREM	ATORY	7 3	1/20/98	BRE	OWTEN	OD.	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NAME	AND ADDRE	SS OF FA	CILITY			023	I II IKT LIKID
	► Kaisu	Dutier	rez					FUNERAL URG RD.			100D,	MD 20722
	23. PART I. Enter the diseases, shock, or heart failt	or complications th	et Caused the de	eth. Do	not enter the m	ode of dy	ring, auc	h as cardiac	or reap	iratory an	reat,	Approximate
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. List only one ca			of p	Œv	NO	mÁ				Interval Between Onset and Death
7	Todaking in doubly	OUE TO	O OR AS CONSEC	DUENCE C	(e):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	DUE TO	O (OR AS A CONSEC	OUENCE (OF):							
FIC	CAUSE (Disease or Injury that initiated events	DUE TO	O (OR AS A CONSEC	DUENCE C	OF):							
RTI	reaulting in death) LAST											
	l										-	
DICAL	PART il. Other aignificant cond	tions contributing to	o death but not r	asuiting	in the underlyi	ng cause	givan in	Part i. 24s	. WAS AN	AUTOPSY RMED?	24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
010	- FINIT	14 1	1000					10	YES	NO		OF DEATH?
ME						1			,			1 TES 2 70
	DID TOBACCO USE CO	NTRIBUTE TO CA	AUSE OF DEA	TH Y	ES 🗆 NO	ZL UN	CERTAI	N 🗆				
CIA	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HØSPITAL:	26. PLAC	E OF DE	ATH (Check only on)						
SI	1 TES 2 NO		☐ ER/Outpatient 3	□ DOA	OTHER:	ma 5 🗆 F	lesidence	6 Other (Sp	ecity)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE O	F INJURY Day, Year)	26b. TII		JURY AT		26d. DESCRIE	BE HOW	INJURY OC	CURED	
BY F	1 Natural 5 Pending 2 Accident Investigat					YES 2	□ NO					
0	3 Suicide 8 Could not	be building	OF INJURY — At ho	me, farm,	street, factory, off	lca		26f. LOCATIO City or To			r or Rural i	Route Number,
TE	4 Homicide determine	ď							,	,		
J.E	29e. CERTIFIER 1 CERTIFYING P	HYSICIAN: To the best of	of my knowledge, de	ath occur	red at the time, da	te end plac	e, end due	o to the cause(e) end ma	nner sa sta	ted.	
COMPLET	000)	MINER: On the basis of	exemination and/or	Investigati	lon, in my opinion,	death occu	ared at the	ilme, date end	place, er	nd due to t	he ceuse(e) end manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERT	IFIER				190 LIG	ENSE NU	MBER 13/		29d. DAT	SIGNED	(Modin Day, Year)
10	30. MANUS AND ADDRESS OF PERSON	WHO COMPLETED CAN	USE OF DEATH (ITE	M 27) (Typ	e, Print)	19178	w 1	1-4 >	IR S	#	WAS	4 MD
	31. DATE FILED (Month, Day, Year)	32. REGISTE	AR'S SIGNATURE	וען	01010	14/0	-/0		<u> </u>	//	7-171	2014A
	MAR 18 1998	Short when	arkacket									/

manufactured and the state of t

VIRGINIA ANN Baltimore, Maryland 21215-0020 TAYLOR,

				Certifica	te of	Death		Reg. No.	9 10	410		
Physician	1. Decedent's Neme (First, Middla, La	est)					2. Date of D Month	eeth Dey	Yaar 3.	Time of Deeth		
/Medical	Ann Virginia T	aylor					Mar.	8 19		12:15		
Examiner			- 1				or Location of Dea	-				
	The Memorial 5. Sociel Security Number 6.5	-		hataus If I Inde	r 1 Year	East		Tall		400		
rector		7. Age	(In yrs. last birt	rs. Months			in. (Month, E	3 1925		(Stete or Foreign Vlvania		
MO W	10e. State 10b. County		10c. City, Town	or Location					10d.	Inside City Limits		
be notified Director	Maryland Caroli	ne	Greens	sboro						1X Yes 2 □ No		
Die S	10e. Street end Number			10f. Zi	p Coda			10g. Citlzan of				
la la					216			U.S.		-0.1		
other traumatic event, the Medical Evantiver must be notified at To Be Completed by Funeral Director		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Detes:	ver in U,S.	13. Was Dece If Yes, spe 1 Yes			(Specify Yes or Nerto Rican, etc.)	lo- 14. Rad Blee	e - American I ck, White, etc. White			
a b	15. Decedent's E		16a.	Decedent's Usu	el Occur	petion		16b. Kind of B				
completed	(Specify only highest green Elamantary/Secondary (0-12)	ede com <i>plated)</i> Collaga (1-4or 5-		(Give kind of wi life. DO NOT u	ork done ise retire	during most of v d)	vorking			,		
Om	11-grad	Collaga (1-401 54		cutive	sec	retary		Playt	ex Corp			
Be C)				18. Mother's N	lame (First, Middl	(First, Middle, Meiden Sumeme)				
To E	Lloyd A. Taylor					Flore	nce Cour	ce Coursey Taylor				
E	19e. Informent's Name/Reletionship (-			Rural Route Num					
5	Mabel Riffle, cou	sin					sboro, Ma	aryland	21639			
any Injury or oth		,										
cian licai iner	23a. Pert1. Enter the diseese, or com shock, or heer failure. List only Immediate Ceuse (Final disease or condition resulting in deeth)	· Chron		stret	de of dyl	ng, such as card		Maryland arrest, , l\second	Api Inte On	proximata ervel Between set end Death		
Aedical Examiner	Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest	C	ue to (or es e c									
etached for use as Physician/Me	Post II Other desidence and distance	d					201 01					
be datached by Physic	Pert II. Other eignificant conditions of	0		the underlying	cause gn	ven in Pen I.		tobacco use co Yes 2□ No	3 Probabl			
P S	andra gar	at a Com	tion				24e. We	s en eutopsy formed?		autopsy findings		
paga 2 should Completed	Cuntury the	or infec	711001				- per	omed?	comple of deet	etion of cause		
Com							1	Yas 20 No	1 □ Ye	s 2 No		
Be	examiner?	Hospital:			Ott	nor	Death (Check only					
15 Pal di		28a. Date of Injury			UA	4 LI Nursing	Home 5 Res	sidence 6 Oth how injury occur				
the funer	1 Neturel 5 Pending investigation	(Month, Dey	Year) In	jury M	28c. Inju Wo 1 □	rk? Yes 2□No	200. 0030/100	now injury occur				
ed in by the funerated in by the funerated in by the funerated in by the funerated in both the funerated in	3 Suicide 6 Could not b	e 28e. Plece of Injur building, etc.		m, street, factor	y, office		28f. Location City or To	(Street end Numt own, Stete)	per or Rural Ro	oute Number,		
Funer taly fill ical		ysician: To the best of niner: On the basis of e end menner stat	examinetion end									
Comple	29b. Signature and title of certifier			29	c. Licens	se number		29d. Date signe	d (Month, Dey	Year)		

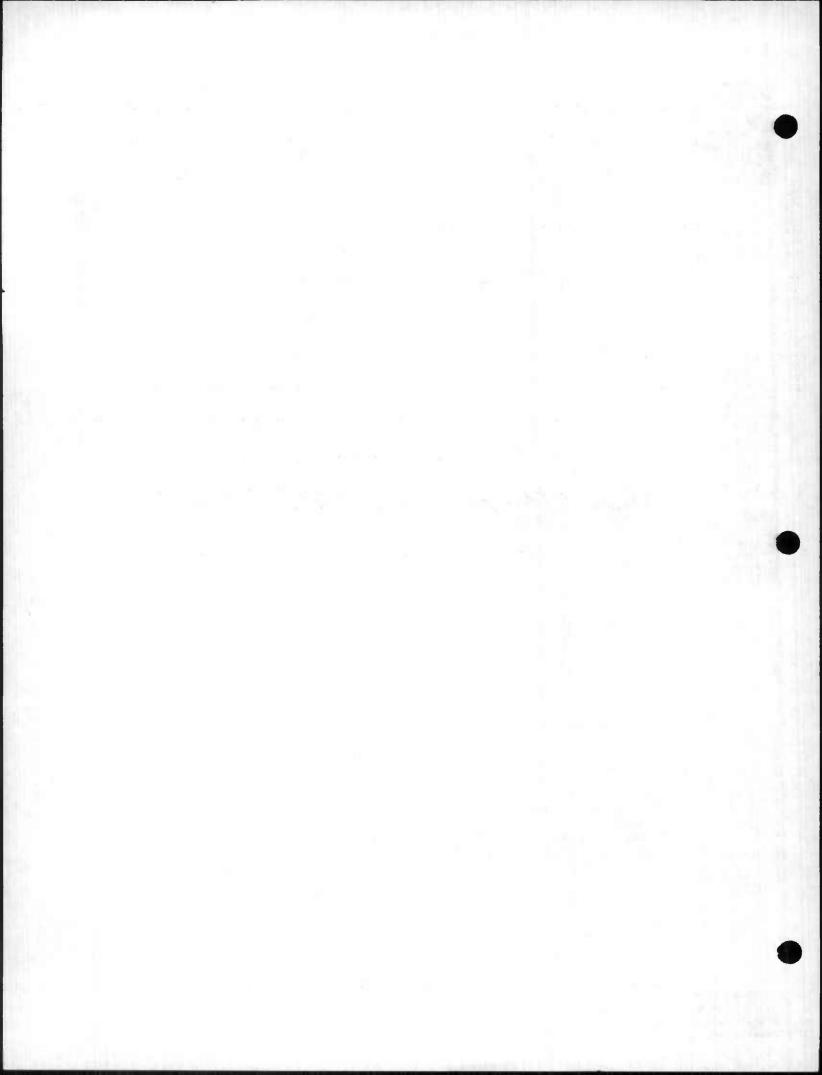
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar

31. Dete filed (Month, Day, Year)

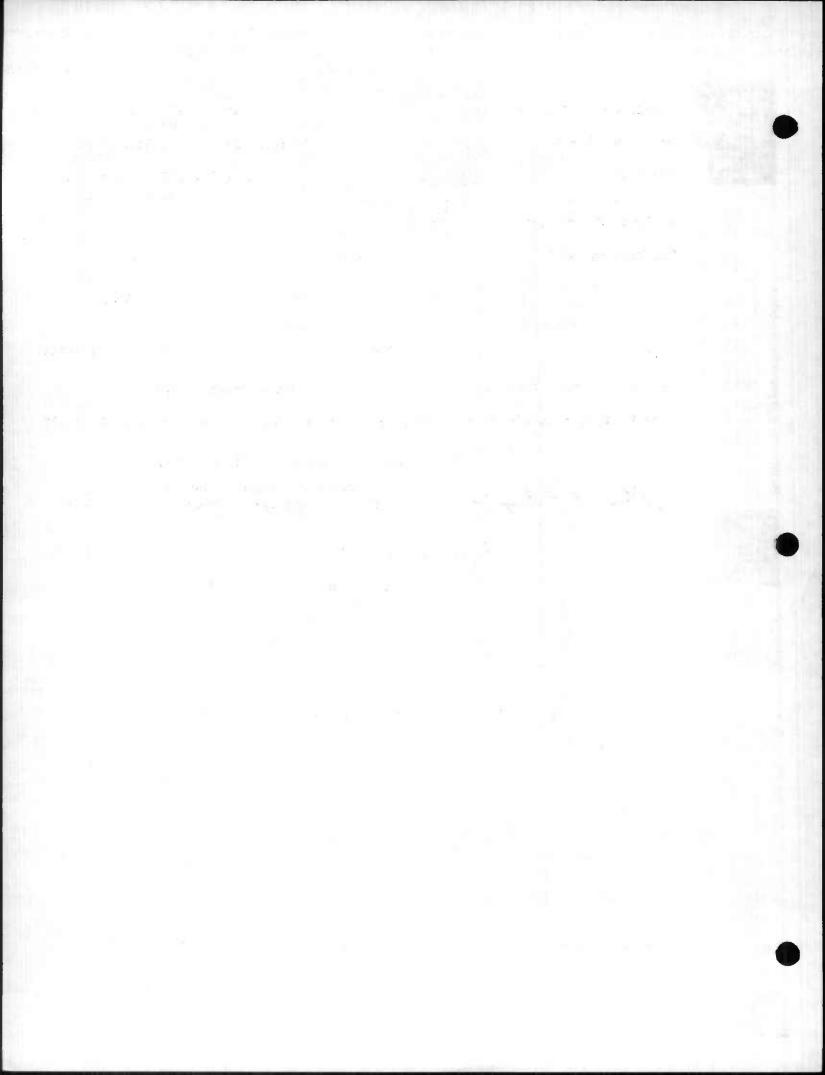


30. Neme end eddrass of person who completed cause of daeth (Itam 23a) (Type, Print)



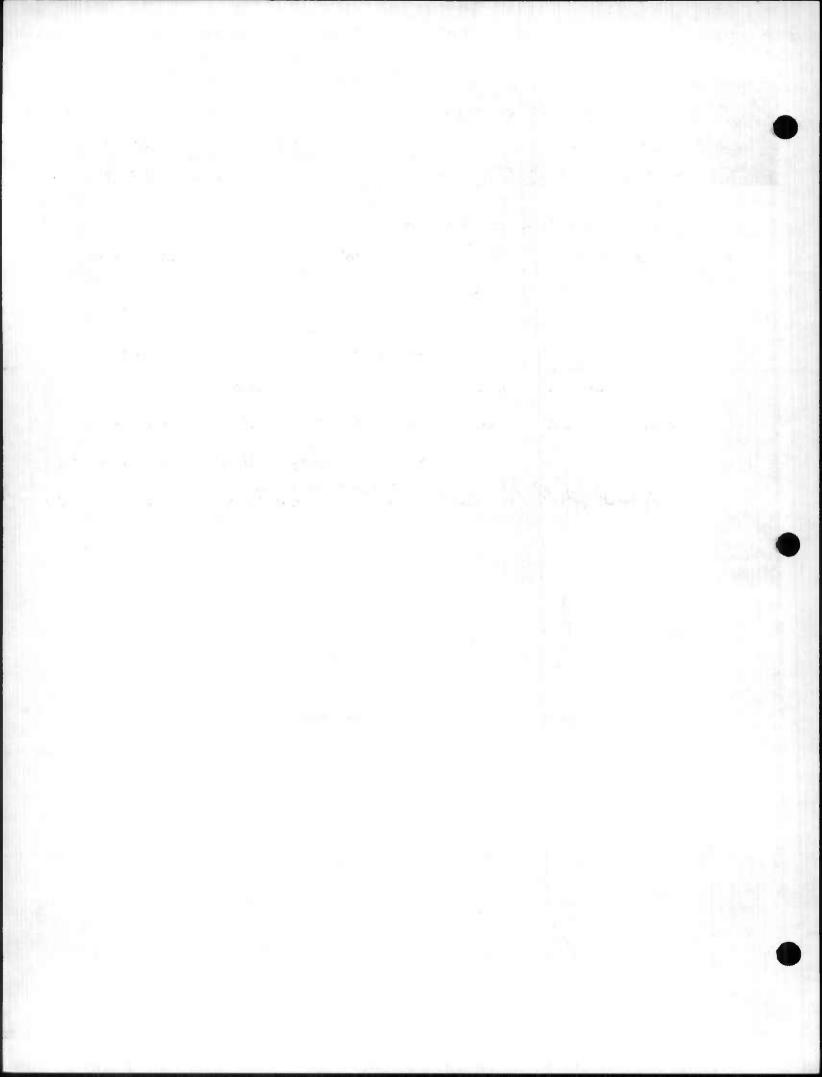
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			Stat	e of Maryland		tificate of			Reg. No.	3	0219
	Physic /Medi		1. Decadant's Nama (First, Middla, Last) William L. Thompson	ı, Sr.				2. Data of Date Month March	Day	Yaar 1998	3. Time of Death 1:05 pm
	Exami		4a. Facility Nama (If not institution, give street at 3611 Barclay Rd	d number)			4b. City, Town, or Lo Templevi	cation of Death	4c. County	of Death	Inne
a.	Funeral Director		5. Social Sacurity Number 6. Sax 1 ™ M 2 □ Usual Rasidence of Decedant	7. Aga (In yrs. le	ast birthday) Yrs.	Months Days	Hours Min.	8. Data of Birt (Month, Day Aug 13,	, Year)		aca (Stata or Foreign try) 1and
	Marylend H show	tor	10a. Stata 10b. County Maryland Queen Anne		Town or Local					10	0d. Insida City Limits 1 ☐ Yas 2√☐ No
	th with the 23a or 28a	al Director	10e. Street and Number 3611 Barclay Road		Cmp1C V	10f. Zip Coda 21670			10g. Citizen of V		try?
020	be filed within 72 hours efter deeth with the Maryland nai Hygiene. ad other than "netural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Nevar Married 2 Married 1 H	Decedant Evar In U,S ad Forcas? Yas 2 1 No s, Giva or Datas:		as Decedant of H Yas, specify Cubi □ Yas 2 1 No	lispanic Origin? (Spe an, Maxicen, Puarto I Specify:	ecify Yas or No- Ricen, atc.)		e - Amarica ck, Whita, a Whit	atc.
Maryland 21215-0020		Completed	15. Decedant's Education (Specify only highast grada comple Elementery/Secondary (0-12) 1 1	ntad) nga (1-4or 5+)	16a. Deceda (Giva k life. De line:		ation during most of workii d)	ng	16b. Kind of Br		Electric
land 2	2 should be filed within n and Mental Hygiene. Is merked other than raumatic event, to a Ma	To Be Co	17. Fathar's Nama (First, Middla, Last) Charles Bradford Thor	npson			18. Mother's Name			na)	
	2 2 E Z		19e. Informent's Name/Ralationship (Type, Prin Dorothy K. Thompson/s	spouse	3611	Barclay	and Number or Aura	21, Tem	plevill	e, MD	21670
Baltimore,	Pages nent of int: If it		20a. Mathod of Disposition H☐ Burial 2 ☐ Cramation 3 ☐ Ramoval A ☐ Donation 5 ☐ Other (Specify)	TOIT Stata	ick Ch	ition (Nama of atory or othar plac urch Cem	etery 3	Data /21/98	20c. Location - Barcla		
Bal	Dependit. Dependent Imports any injects.		21. Signature of Funarai Sarvice Licensaa 22. Nama and Addrass of Facility Fleegle & Helfenbein Funeral 106 W. Sunset Ave., Greensbor 23a. Partl. Entar tha disaasa, of complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast,								21639
ì	Physician /Medical		shock, or haert failura. List only ona cause Immediata Causa (Final disaese or condition	on aach lina.		Failur		i raspiratory ar	ra5t,	1	Approximate Infarval Batween Onsat and Death
	Examiner	liner	resulting in death) a	Due to (or	as a consequ	ance off:	der luete	es tuti	-	1	
Box 68760,	eath certificate be executed ettending physician and I for use as the buriel-transit	n/Medical Examiner	Sequantially list conditions, if any, leading to Immadiata ceusa. Entar Undarying Cause (Diseesa or injury that initietad avants rasulting in death) Last		as a consequ						
Ö	the death y the ette ched for	Physician/M	Part II. Other significant conditions contributing			, ,		1			the cause of death?
ords, P.	law requires thet the death centi as been signed by the ettending to 2 should be deteched for use a	þ	COPD/ lusta static	/ BPH	ur et	Brain M	iets.	24a. Was		24b. Wa	ra eutopsy findings
al Rec	The ate h	Completed		(1)				1 D Y	as 2 No	of o	nplation of causa feath?
n of Vital Records,	To the Hospital or Attending Physician: The within 24 hours electeath. To the Funeral Director: After this certificate completely filled in by the funeral director, par	n: To Be	25. Was cesa raferred to medicel exeminar? 1 ☐ Yas 2 ☐ No Hospital: 27. Menutor of Death 28a.		ER/Outpetient 28b. Tima of Injury	3 DOA Oth	4 Indising nor	ne 5 Resid)
Division	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined 28e.	Plece of Injury - At hor building, atc. (Specify)	ma, farm, stree	M 1 🗆	Yas 2□No	28f. Location (S City or Tow		per or Rural	l Routa Number,
	No Hospital	edicai C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	o tha bast of my know ha basis of axamination	riedge, death o on and/or inva	occurred et the tirestigation, in my o	na, data and place, a plnion, daath occurra	and dua to tha d ad at tha tima, d	eusa(s) and ma data and place,	anner as sta and dua to	ated. tha causa(s)
	To the Within To the Comp	Me	29b. Signatura and titla of certifiar	D		29c. Licans	a number 0996		29d. Data signe	d (Month, L	Jay, Year)
			30. Name and addrass of person who complated Deil Stadaard MD	100 Bro	wnSt		ortown	MD Z	1650		
	Sta Registr		31. Data filad (Month, Day, Yaar) MAR 2 0 °98	32. Registrar's Signatu Suna Dav		ndalle					



State of Maryland / Department of Health and Mental Hygiene

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П	Physici	an	1. Decedent's Nama (First, Middle, Las	t)					2. Dete of De Month	eeth Dey	Yeer	3. Time of Death	
	/Medi Examir	cal	Cecile 4e. Facility Name (If not institution, give	Elmire T	illie	r		4b. City, Town, o	Marcl or Location of Dea	n 13, 1	1998 y of Deeth		
			Homestead Mano				W44 4 434	Dent			Caro		
	Funeral Director		5. Sociel Security Number 6. Security Number 039–18–2610 Usuel Residence of Decedent	ox 7. Ag □ M 2□ _X F	e (In yrs. la: 88	st birthday) Yrs.	ff Under 1 Yee Months Deys			8, 1910	g. Birth Cou Rhoc	pleca (Stete or Foreign intry) le Island	
	show		10a. Stete 10b. County		10c. City,	Town or Loca	ation					10d. fnside City Limits	
	the Ma 28a-1	ecto	Maryland Dorches 10e. Street end Number	ter	Woo.	lford	10f. Zip Code			10g. Citizen of	M/hat Car	1 ☐ Yes 2 No	
	th with	al Di	5123 Brooks Road				21677			United		-	
020	be filed within 72 hours efter death with the Maryland itsi tygiene. d other than "naturel", or items 23a or 28a-f show event, the Modical Examiner must be notified at	by Funeral Director	11. Maritef Stetus 1 Navar Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedant Armed Forces? 1 Yas 2 1 1 Yes, Give Yeer or Detes:			as Decedent of Yas, specify Cul	Hispenic Origin? ban, Maxican, Puo Specify:	(Specify Yas or Norto Rican, etc.)	Specil	ick, White		
Maryland 21215-0020	within 72 ho iene. than "natur the Wedical	Completed	15. Decedent's Ed (Specify only highest green Elementery/Secondery (0-12)	ucation de com <i>pleted)</i> College (1-4or 5	5+)	16e. Decede (Give ki life. Do		ipation a during most of w ed)	vorking	16b. Kind of B	-		
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Mar	le she is me		19a. Informent's Neme/Ralationship (7					et end Number or		•			
	is 1 and 2 should of Health end Mer Nem 27 is marks other traumatic		Ronald M. Tillier 20e. Method of Disposition	Son	20b. Pie		Brooks tion (Neme of etory or other pl	Road, Wo	Olford,	Maryland 20c. Location		.677	
Baltimore,	Pages ment of ant: If It ury or o		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				etory or other pl h's Cem					Rhode ck, Island	
Balt	permit. Pages 'Department of H Important: If the any injury or of once.		21. Signeture of Funerel Service License			rland 21629							
	all and		23a. Part1. Enter the disaasa, or comp shock, or heert feilure. List only	iications thet causad	tha daath. ne.	Do not anter	the mode of dy	ing, such es card	ac or respiretory	errest,		Approximate Interval Between	
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,0	tificate be executed g physician and es the buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	b	Due to (or es e consequenca of):								
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of	Phys or this oral di	 -	1 Yes 2 No 27. Menner of Deeth	28e. Dete of Injur	ry 2	R/Outpetient 8b. Time of	3□ DOA 28c. Inju	PEI Nursing	Home 5 Res	idenca 6 □Otl how injury occu		fy)	
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	To the within 2 To the comple	≥ 29b. Signature and title of certifier 29d. Dete signed (M											
			30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) A Tray Donton, MD Po Both 122 Golds boro, MO 2/679 31. Dete filled (Month, Day, Year) 32. Registrar's Signature 2011-1014									8	
			30. Name end address of person who c	-	eeth (Item 2	(Type, P	rint)		1			2	
			31. Dete filed (Month, Day, Year)	32. Registre	10	Box.	122	Crolds.	boro, 1	nO 2	162	7	
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JNA	LD S.	TF	IOMPSON S	State of Maryland / Department of Health a	nd Mental Hygie	ene	10001
ASP			4 Danadasta Nama (Final Middle Last)	Certificate of Death		J. No. 7 0	2 Time of Death
	Physicia	in	1. Decedent'a Name (First, Middle, Last)	att It - asan	2. Date of Deeth Month	Dey Yee	
1	/Medic Examin		4e Fecility Neme (If not institution, give stre	net and number) 4th City, Tow	m, or Location of Death	06 , 1998 4c. County of De	3:50 A
		•	ROUTE#424 & ROUTE	# 50 Davk	Isonville	ANNE AI	RUNDEL
	Funeral Director		5. Social Security Number 222-72-8989 150 M Usual Residence of Decedent	7. Age (In yrs. last/birthday) 2 F Yrs. Hours Deys Hours	Min. (Month, Dey,)	(ear) 9. B	Syntholiace (State or Foreign Spuntry)
	death with the Meryland me 23a or 28a-f show	tor	10a, State 10b. County 10b. Co	tle New Ostle			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28	Funeral Director	10e. Street end Number	10f. Zip Code	100	g. Citizen of What	Country?
	eath v	eral	11. Marital Stetus 12.	Wes Decedent Ever in U,S. 13. Was Decedent of Hispanic Original	in? (Specify Yes or No-	14. Race - Ar	merican Indian,
020	urs efter	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:	Puerto Rican, etc.)	Specify:	
21215-0020	n 72	Completed	15. Decedent's Educati (Specify only highest grade co	on 16e. Decedent's Usual Occupation (Give kind of work done during most lift. DO NOT use refined)	of working	Bb. Kind of Busines	ss/Industry
212	s 1 and 2 should be filed within if Health end Mental Hygiene. Item 27 ie marked other than other treumatic event, the M	E O	Elementery/Secondary (0-12)	College (1-40r5+) Pipe titter		Heat	ing
pue	should be filed nd Mental Hygi merked other imetic event,	Be	17. Father's Neme (First, Middle, Last)	//10	's Name (First, Middle M	aiden Sumeme)	1.5
Maryland	2 should end Mer le marke eumatic	10	19a. Informant's Neme/Belationship (Type,	Print) 19b. Mailing Address (Street and Number	or Rurel Route Number	City of Town, State	J. Zip Code)
-	and 2 is m 27 is her treu		Walter B. Thomas	oson Father 5629 Sudlersvi	ille RdJu	dersuil	k, MD 2/66
Baltimore			20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place of Disposition (Neme of emetery, cremetery prother place)	Date 20	C. Location - City	or Town, Stete
Him			4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee	JOHN PEVETANS MEN. 16 22. Name and Address of Facility	W. 711 78	Sear, I) el avave
Ba	permit. Departm Importar any Inju		21. Signature of Current Service Literature	10rbert Fun	Copy Crape	Samo 1	V= 10001/
			23a. Part1. Enter the disease, or complicat	ions that caused the death. Do not enter the mode of dying, such as cleuse on each line.	cardiec or respiretory arres	Joves , L	Approximete Interval Between
	Physician			Dada OC	111	٨	Onset and Death
al	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting In death)	flabored burg	rel no	red	
		ner		Due to (or as a consequenca of):			
	be axecuted iclan end burial-transit	Examiner	Sequentially list conditions,	Due to (or as a consequence of):			
8760,			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events				
9	g phys	edic	resulting in death) Lest	Due to (or es a consequenca of):			
Box	auth certific attending p for use as	an/N	d				
P.O. E	that the daath certific ed by the attending p detached for use as	ysici	Part II. Other significant conditions contrib	uting to death but not resulting In the underlying cause given in Part I.		14	ute to the cause of death?
	that the	Y P			1 Yes	2 No 3	Probably 4 Unknown
Records,	lew requires that as been signed b	Completed by Physician/Medical			24e. Was an performe		b. Were autopsy findings aveileble prior to completion of cause of death?
I Re	ilcian: The lev certificate has rector, pega 2	EOC			1 Xyes	2 □ No	1 Yes 2□ No
of Vital	Physician: this certific	To Be	25. Was case referred to medical examiner?	No. 1	of Death (Check only one,		
of	To the Hospital or Attending Physician: The is within 24 hours aftar death. To the Funeral Director: After this certificate he complataly filled in by the funeral director, paga	2	IN THE ZUNO	28a. Date of Injury 28b. Time of 28c. Injury at	rsing Home 5 Residen 28d. Describe how		pecity) ROADWAY
Division	Attending ir death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury M 1 Yes 200	10 Subj.	ect she	stself
ivis	or Attendiates death. Director: A in by the f	1112	4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street) O City or Town,	stete)	Rural Route Number,
۵	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this complataly filled in by the funeral di	edical Certification:	29a. Certifier 1□ Certifying Phyaici	an: To the best of my knowledge, death occurred at the time, date and	OT HE 92	of all the	C, SO
	To the Hospital within 24 hours To the Funeral complataly filled	dica		on the basis of examinetion and/or investigation, in my opinion, death and manner stated.			
	withir To th comp	X	29b. Signature and title of certifier	29c. License number		d. Date signed (Mo	
			1) aunt	rleW) O.C.M.E	M	ARCH 06,	7330
			30. Name and edgress of person who comp	leted cause of death (Item 23e) (Type, Print) 111 Penn Street	t. Raltimore	Marvla	nd 21201
	Stat	е	31. Date filed (Month, Dey, Year)	32. Registrar's Signature	-, barchiore	, rany ru	
	Registra	_	MAR 10 '98	This Davidson-Randell			

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State of Maryland / Department of Health and Mental Hygiene

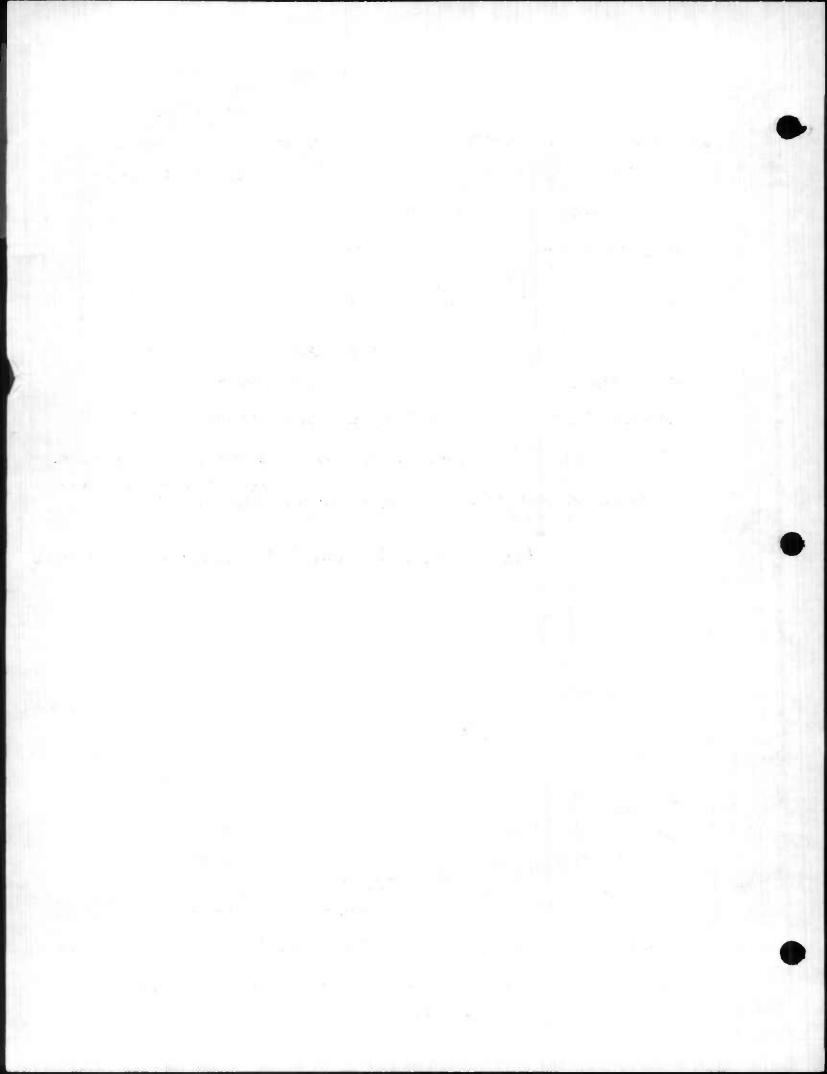
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Walter Vetter Jr. Mar. 16 1998 10:14 am /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Continuum Care at Sykesville Sykesville Carroll 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Date of Birth (Month, Dey, Year) **Funeral** 1√2 M 2□ F Months Days Hours 220-05-7798 Yrs. 78 Director Oct. 29 1919 Germany Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rei', or itams 23a or 28a-f shov Examiner must be notified at Md. Sykesville Carroll 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 6910 Sheffield Drive 21784 pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itams 23a any injury or other traumatic event, the Medical Example Death and ODGB. Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 1041 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien. Black, White, etc. 1√2 Yes 2 No 1941— If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) tool & die maker machinery 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Walter Vetter Sr. Elfiede Wernscheid 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gary Vetter (son) 6177 Oak Hill Dr. Sykesville, Md. 21784 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 3-19-98 Marriottsville, Md. 22. Name end Address of Facility 21. Signature of Funerel Service Licansee Haight Funeral Home & Chapel · 0/. P.O. Box 195 Sykesville, Md. 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Interval Between Onset end Deeth **Physician** · METASTATIC RENAL CARCINDONA /Medical Immediate Ceuse (Fine) disease or condition resulting in deeth) Examiner Examiner the death certificate be executed pue Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician er s the buriel-t Box 68760. Physician/Medical Due to (or es e consequence of) use P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Onknown 1 Yes 2 No Records, Completed by 24b. Were autopsy findings eveileble prior to 24a. Wes en eutopsy performed? peen completion of cause of death? page 2 1 Yes 2 → No 1 Tyes 2 No certificata Division of Vital To the Hospital or Attanding Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica complataly filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Naturel 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated.

| Certifying Physician: To the basis of examiner: On the basis of examiner and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 40390 MARCH 17, (998 ATTENDING 30. Name and address of pareon who completed cause of death (Item 23a) (Type, Print) Dey, Year) 32. Registrer's Signature

R181998 July Muchor Revolution PANKAJ R 31. Dete filed (Month, Dey, Year) State Registrar MAR 1 8 1998

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 21521 LAD MARCH 14 /Medical 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. 8. Date of Birth Hours Min. February 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Securify Number 9. Birthplace (State or Foreign Country) 2 New York 6. Sex **Funeral** Months Days 10,1932 1□ M 2Q F 106-22-2782 65 Yrs. Director Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23s or 28s-f short Examiner must be notified at Director 1 Yes 2 □ No Maryland | Montgomery Silver Spring 10e. Sfreef end Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with inent of Heelih and Mental Hygiena.
Int: If Item 27 is marked other than "natural", or items 23e or intro yor other traumatic event, The Medical Energy of the resumatic event, The Medical Energy of the Peges Energy 531 Randolph Road #215 20904 U.SA. Funeral 12. Was Decedenf Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☐ No à Specify: Black 3₺ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 4 yrs. Communications Specialist Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry C. Chambers Ophelia Taylor 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Lawson-Daughter 58 A Sharon Street, Brooklyn, New York 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Data 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of Important: If any Injury or 3 - 20Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Marshall's Funeral HOme, Inc. Mars Form. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximata nterval Between Onset and Death **Physician** /Medical Immediata Cause (Final INFARCTION & MYOCARDIAL disease or condition resulting in death) ACUTE Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed use es the buriel-transi Sequentially list conditions, if any, laading to Immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in deeth) Last and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medicai Due to (or as a consequence of) Part 1i. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 2 1 Yss 2 No 3 Probably 4 Unknown signed t Records, by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eufopsy page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director, Be 25. Was case raferred to medical 28. Place of Death (Check only one) axaminer? 12 Yes 2 □ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending Invastigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicida To the Hospital within 24 hours a To the Funeral D Medicai 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian completaly 29b. Signature and title of a 29c. License number 29d. Date signed (Month, Day, Year) 007099 eted cause of death (Item 23a) (Type, Prinf) FERNWOOD RD AYLE 10215 31. Data filad (Month, Day, Year) 32 Registrar's Sign State MAR 17 1996 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Yaar Weinstein MARCH 14, 1:35 AM 1998 /Medical 4a. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Daeth 4c. County of Daath Examiner MONIGOMERY Potomac Valley Nursing Home Potomec If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funerai** Days Hours 1 □ M 2 1 1 F Yrs Director 082-01-7423 98 DECEMBER 18, 1899 NEW YORK Usual Rasidance of Dacedeni with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ns 23a or 28a-f sh 1 ☐ Yes 2 No Director **MARYLAND** ROCKVILLE MONIGOMERY 10e. Street end Number 10f. Zip Coda 10g, Citizan of What Country? 20854 UNITIED STATES OF AMERICA 1235 POTOMAC VALLEY ROAD Funeral death 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☑No If Yas, Giva Yaar or Datas: Hems Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - Amarican Indian Black, Whita, atc. "natural", or Itan filed within 72 hours after 1XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowad 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedant's Education 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Hygiene. Elementary/Secondery (0-12) Collaga (1-4or 5+) 12 CREDIT MANAGER MILINARY FIRM marked other 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Surnama) Be Pages 1 end 2 should be 1 nent of Heelth and Mental I SAMUEL WEINSTEIN EYA SAPERSTEIN 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 60 Heelth a 7208 MILLWOOD ROAD, BETHESDA, MARYLAND 20817 STANLEY COHEN NEPHEW or other 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 🗷 Ramoval from Stata Department of Important: If any injury or KING DAVID MEMORIAL GARDENS 3/15/1998 FALLS CHIRCH, VIRGINIA 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signulario di Europeal Sarvice Licansee 22. Nama and Addrass of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part Emer the disease, or complications that ceused the deeth. Do not anter the mode of dylng, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batwaan Onset end Death **Physician** /Medical Immediata Cause (Final CONCESTIVE HEART FAILURE 1 MONIH disease or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE The law requires that the deeth certificate be executed the burial-transit Sequentially list conditions, if any, leading to Immadiata causa. Enter Underlying Cause (Diseasa or Injury that Initiated avents rasulting in death) Last Dua to (or as e consequance of) P.O. Box 68760. Physician/Medical Dua to (or es e consequance of): USB 88 ettending for signed by the eld be deteched for Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to complation of ceusa pege 2 should Completed 24a. Was an autopsy hes 1 ☐ Yas 2 ੌ No 1 ☐ Yas 2 ☐ No certificate Vital or Attending Physician: director. Be 25. Was cesa referred to madice 28. Place of Death (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 2KNo Certification: To of this illed in by the funeral 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Division After 5 Panding Invastigation 1 DNatural 1 ☐ Yes 2 ☐ No death 2 Accidant efter death 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicida Hospital within 24 hours e 1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, data and place, end due to the causa(s) and manner as steted.

| Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifian Medical completely (Check only one) the 29b. Signature and 29c. License number 0 29d, Deta signed (Month, Day, Year) March 14, 1998 D01120 30. Nama and addrass of person who completed cases of death (from 23a) (Type, Print) WALTER GOOZH, MD 1299 LAMBERION DRIVE, SILVER SPRING, MARYLAND 20902 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 15°, Month John Joseph Witmer 1998 1:50 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 6808 Pyle Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Feb. 10, 19 Birthplace (State or Foreign Country)
 Ohio 7. Age (In yrs. lest birthday) **Funeral** Days Hours 1⊠M 2□ F 265-62-2374 Yrs. Feb. 60 Director 1938 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Tyes 2k No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6808 Pyle Road 20817 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Never Married 2 ☑ Married 1 Yes 2X No Specify: by Specify: 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene, important: if Item 27 is merked other than "netu any injury or other traumatic avairance." 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Embassy School 5+ Educator 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) Be Ezra Witmer Lulu Shaum 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Janet C.P. Witmer/Wife 6808 Pyle Road, Bethesda, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State March 17, 1998 Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signeture of Funerel Service Licensee buch 0 M00198 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line, Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel 2 years Amyotrophic Lateral Sclerosis disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician a Physician/Medical Due to (or es e consequence of) for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed should be det þ Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attanding Physician: The safter death.

In Director: After this certificated in by the funeral director, pa Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funaral Di completely filled in edical 29a. Certifier 1 🔀 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner as steted. 2 Medicat Examiner: On the basis of examination end/or Investigation, In my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D39563 March 16, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Susan G. Baruch, M.D. 10215 Fernwood Road, Bethesda, Maryland

that the death certificate be executed

The lew requires

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certificate

Box 68760

P.O.

Records,

Division of Vital

the Maryland

death

72 hours efter

Baltimore, Maryland 21215-0020

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Items 23a

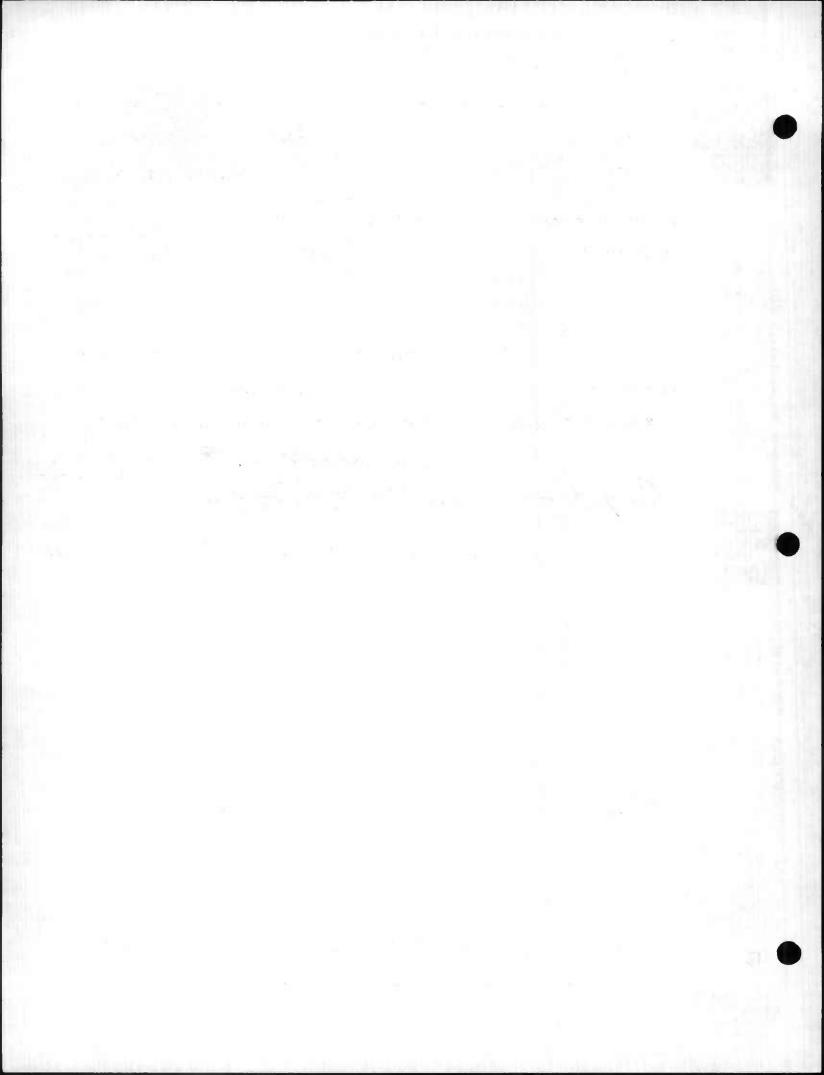
natural', or

31. Date filed (Month, Dey, Year) State Registrar

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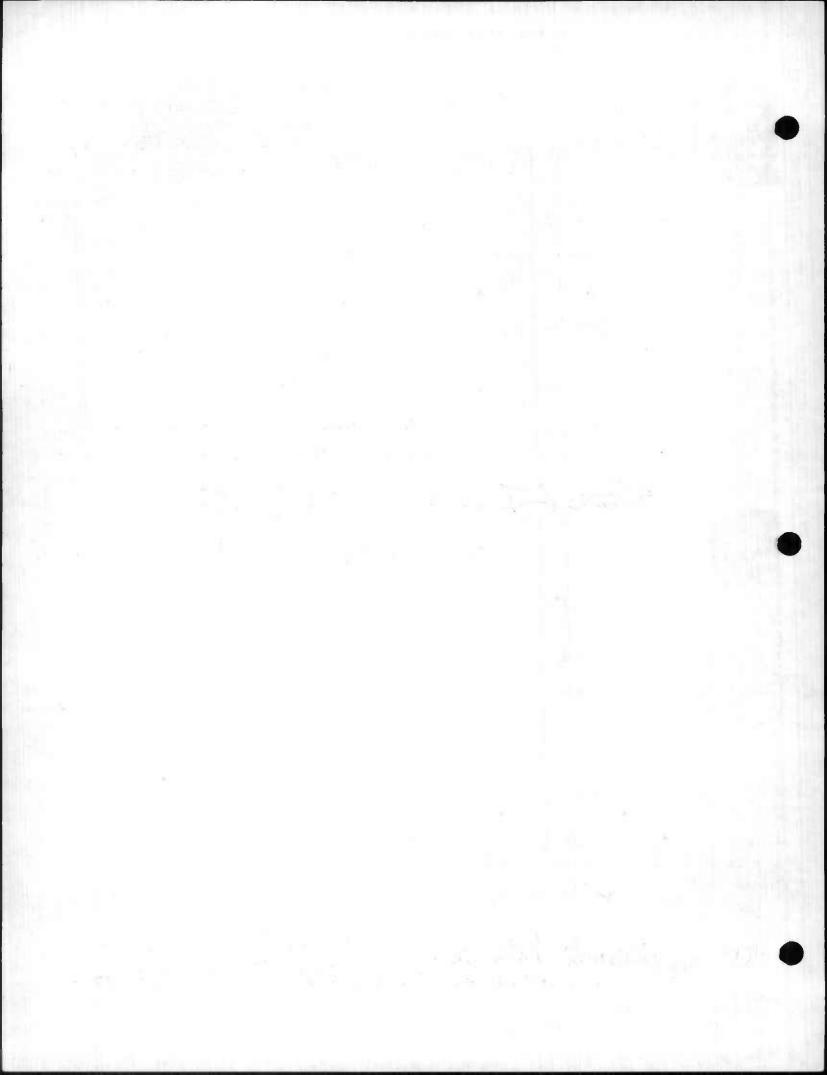
Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 98

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12		10a. Stata 10b. County		10c. Cit	y, Town or Lo	ocation				10d.	Insida City Limit
g	o	Maryland Montgom	orv	Pot	omac						1 Yas 2NN
Examiner must be notified at	2	10e. Street and Number	Cly	100	Omac	10f. Zip Coda			10g. Citizan of	What Country?	
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9	Funeral Director	11. Marital Status	12. Was Deced	dant Evar in U.	,S. 13.			n? (Specify Yas or No Puarto Rican, atc.)		ce - Amarican II	ndian,
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omer		Emanuel Wolman	/ spouse			0 Windso	r View		omac, MI		
5		20a. Method of Disposition 1 ■ Burial 2 □ Cramation 3 □	Ramoval from S	tota C	amatary, crar	nsition (Nema of malory or other pla		Data		- City or Town,	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:52 am 10, Joseph F. Waclawski. 1998 March /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 24, 1910 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 ☐ F 213-09-8314 88 Yrs. Maryland **Director** Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Examiner must be 354 Oak Drive 21012 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Meritei Status Bleck, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White à 3 Nidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) General Plumbing Elementery/Secondery (0-12) College (1-4or 5+) Supply, Co. President/Owner \$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental John Waclawski Magdalene Giza 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health. Nam 27 i Eileen Trescott/daughter 472 Cedar Haven Rd., Arnold, MD 21012 20b. Placa of Disposition (Neme of cametery, cremetory or other place) Mar 13 20c. Location - City or Town, State 20a. Method of Disposition Department of Hi Important: If the any injury or off 1 Burial 2 □ Cremation 3 □ Removal from State Elkridge, MD Meadowridge Memorial Park 1998 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Furtheral Service Lighty 495 Gov. Ritchie Hwy., Severna Park, MD that I Erter the disease, or complete shock, or heart failure. List only or Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition results g in death) Examiner Examiner Fall physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Pneumonia Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): non Hodgkins type homa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pseudo Small Bowel obstruction - ileur by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Chronic Obstructive Pulmonary disease Completed Congestive Heart Failure 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this 27. Menner of Deeth

1. Neturel

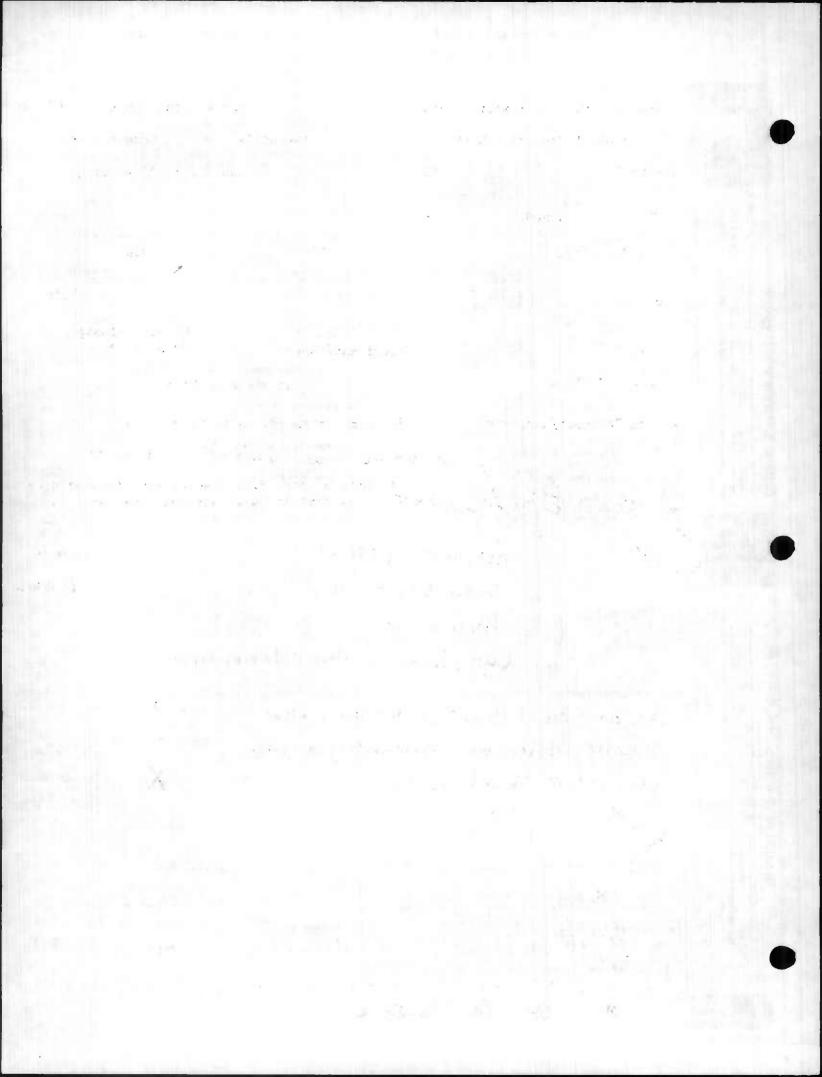
2. Accident 28d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28b Time of 28c. injury at Work? Certification: 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) 29e. Certifier Medical (Check only one) end manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature em 29c. License number 0 1732654 of person who completed cause of death (Item 23e) (Type, Print) Ritchir Hyhnay, Arnold, MO 21012 Serlenitor 1509 32. Registrar's Signature State

Julia Davidson-Randall

Registrar

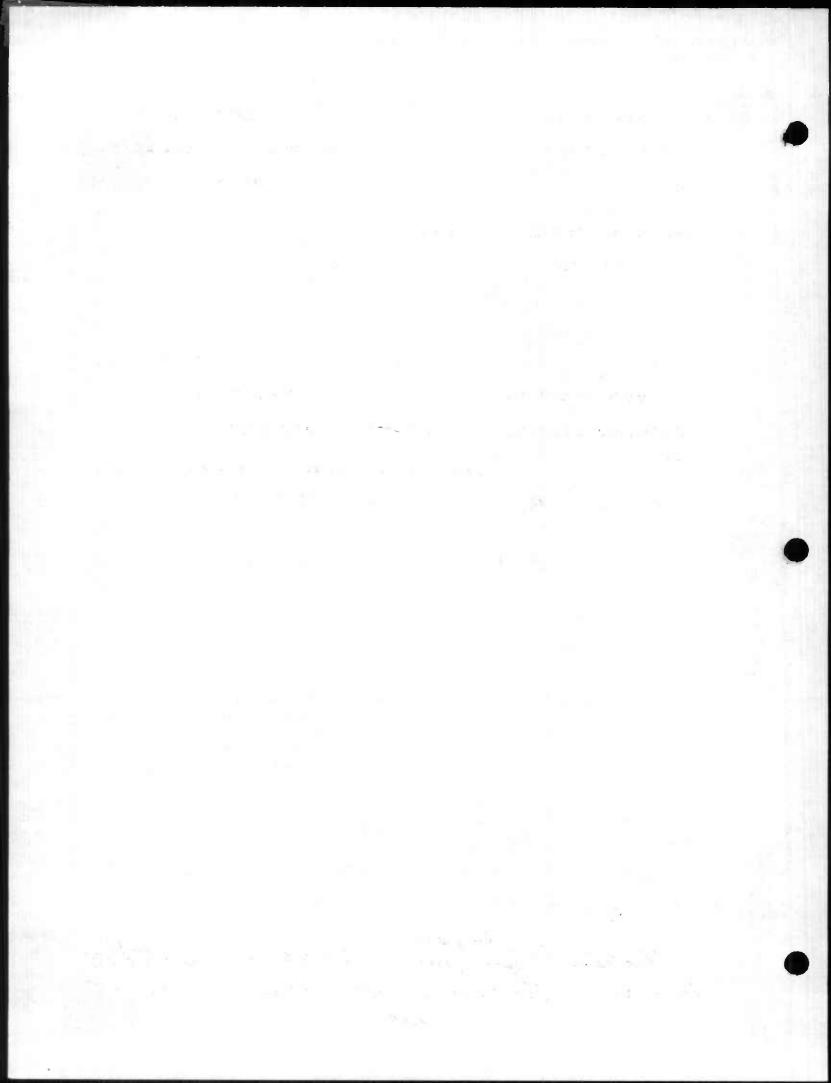


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** 1998 MARCH 4 /Medical BERNARD WALLACE 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ANNAPOLIS ANNE ARUNDEL 1020 MONROE STREET If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months 1 ☑ M 2 □ F Director 62 AUG. 4 1935 MARYLAND 219-30-1143 Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be nothing at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 6 238 1020 MONROE STREET 21403 US Funeral Rems 2 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give "naturel", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than . permit. Pages 1 and 2 should be filed withis Department of Health and Mantal Hygiena. Important: If flem 27 is marked other than enty injury or other treumatic event, the Mones. Elementery/Secondery (0-12) College (1-4or 5+) 12th US NAVAL ACADEMY LANDSCAPER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be JENNIE STANLEY 2 BERNARD W. WALLACE SR. 19e. intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BERNICE JOHNSON (SISTER) 1769 RICHFIELD DRIVE SEVERN, MD. 21144 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1XXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/10/98 ANNAPOLIS, MD. ANNAPOLIS MEM. GARDENS 22. Neme end Address of Fecility WM. REESE & SONS MORTUARY, P.A. Beese Larry 1 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart fellure. List only one cause on each line. **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Heart Disease Arteriosclerotie Examiner Due to (or es e consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 88 attending p for use as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown þ should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed certificata has b 1 Yes 2 XNo director, 80 25. Wes case reterred to medical 26. Place of Deeth (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Affar 1 Matural 5 Pending after death.

Director: Aft.
d in by the fur 1 Yes 2 No 2 ☐ Accident Investigetion 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di letaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29a. Certifier Medical within 24 ho To the Functional (Check only one) 29b. Signeture end title of certifler 29c. License number 29d. Date signed (Month, Dey, Year) Deputy D 06054 MD 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) 695 America Villiam TONES, MD 31. Dete tiled (Month, Day, Year) 32 Registrer's Signeture State MAR 1 0 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day **Physician** 1998 HELEN J. WILSON MARCH 7 /Medical 0400 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year 5. Sociei Security Number if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1□M 2⊠F Months Yrs. 220-24-3770 83 NOV. 26 1914 MARYLAND Usuei Residanca of Decedant 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MARYLAND ANNE ARUNDEL EDGEWATER 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 112 MILL SWAMP ROAD 21037 US Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No þ Specify: BLACK 3XXWidowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 7th 0 DOMESTIC OUT OF THE HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be CHARLES JOHNSON MARY PARKER 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) DORIS A. TONGUE (DAUGHTER) 124 MILL SWAMP ROAD EDGEWATER, MD. 21037 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State CHEWS UM CHURCH CEMETERY 3/11/98 OWENSVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
WM. REESE & SONS MORTUARY, P.A. 21. Signature of Funerel Servica Licensee Neese 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Pert1. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or hear feilure. List only one cause on aach lina. Approximata Interval Between Onset end Deeth Immediete Ceuse (Finel diseese or condition rasulting in deeth) Examiner Sequantially list conditions, if eny, leeding to immediate cause. Entar Underlying Ceusa (Disaase or injury thet initieted events resulting In deeth) Lest Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of daath? 24e. Wes en eutopsy performed? Completed 1 ☐ Yas 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical exeminar? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) edical Certification: To 1 Hapatient 2 □ ER/Outpetient 3 □ DOA 27. Manney of Death 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturel 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29e. Cattle Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted. (Chack anly 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and addres d person who completed cause of death (Itam 23e) (Type, Print)

State Registrar

31. Dete filed (Month, Day, Year)

MAR

1 0 1998

32 Registrar's Signeture Fundale

Funeral

Director

28a-f show

6 items 23a

other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter c Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumetic event, the Medical Evanina.

Physiclan /Medical

Examiner

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Aftar

hours after death. uneral Director: A sly filled in by tha le

within 24 hours a
To the Funeral C
completely filled

death.

that the death certificate be axecuted

The law requires

To the Hospital or Attending Physician:

Box 68760

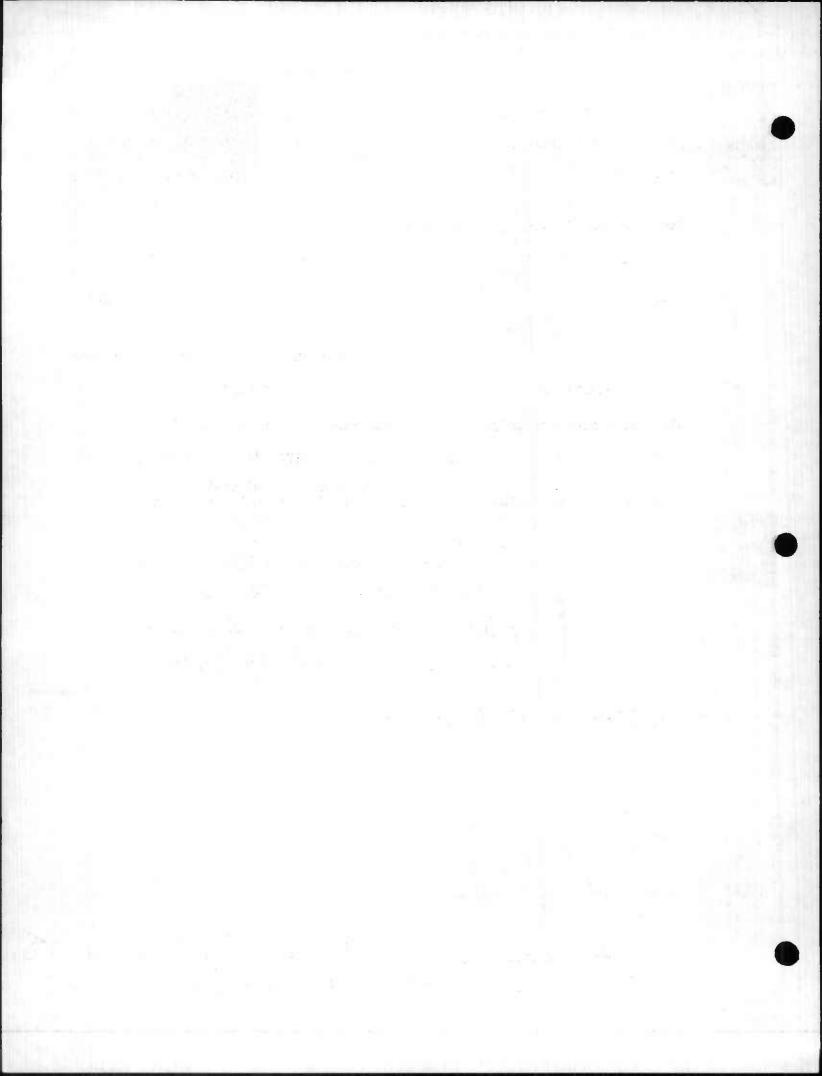
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Records,

Division of Vital

Baltimore, Maryland 21215-0020

the Maryland



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DERRICK DITT T T ANC State of Maryland / Department of Health and Mental Hygiene () Certificate of Death

20, 1998 4c. County of Deeth

CHARLES

3. Time of Death

2:45A.M.

2. Dete of Deeth

Month

4b. City, Town, or Location of Death
LA PLATA

LIVISTA

MI	LLLAMS
	Physicia

/Medical Examiner 1. Decedent's Name (First, Middle, Last)

5. Social Security Number

DERRICK LEE WILLIAMS

LIVISTA MEDICAL CENTER

4a Facility Neme (If not institution, give street end number)

Funeral Director

the Maryland show r 28a-f show r than "natural", or itams 23s or the Medical Examiner must be death

filed within 72 hours after Hygiene. Pages 1 and 2 should be facilities of Health and Mental I in: If itsm 27 is marked of permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

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Box 68760

of Vital

Division

sician and burial-trans physician s the burial 60 use tha 2 Deen has certificate this uneral After t A Hospital or Atta.

* hours after death.

* Director: A*

* hours atternative the control of th

6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) Deys Months Min. Hours 213-19-4602 18 JAN. 21, 1980 WASHINGTON, D.C. Usual Residence of Decedent 10d. inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 □ No Directo MARYLAND CHARLES INDIAN HEAD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 WOODLAND DRIVE 20640 UNITED STATES 14. Race - American indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. 11. Maritel Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CHARLES COUNTY PUBLIC Elementery/Secondery (0-12) College (1-4or 5+) SCHOOL SYSTEM 12TH GRADE STUDENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) ROBERT CLIFFORD WILLIAMS DALE EVELYN BELFTELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7 WOODLAND DRIVE, INDIAN HEAD, MARYLAND DALE E. BELFIELD / MOTHER 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
14 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 20c. Location - City or Town, State ST. JOSEPH'S CHURCH CEM. 3/24/98 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. South MAIA C. JOHASON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of) Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopay findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 No ON Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 2 1XXYes 2□ No 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 98 5 Pending investigation 1 Natural Injury Va SUL 81 auso 20 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street and City or Town, Stete) 3 Suicide Street and Number or Rural Route Number 28e. Place offnjury - At home, farm, street, factory, office building, etc. (Specify) Homicide BAR Road LOTA 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated edical Madical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 O.C.M.E. MARCH 21,1998

State Registrar 31. Date filed (Month, Day, Year) MAR 2 3 1998

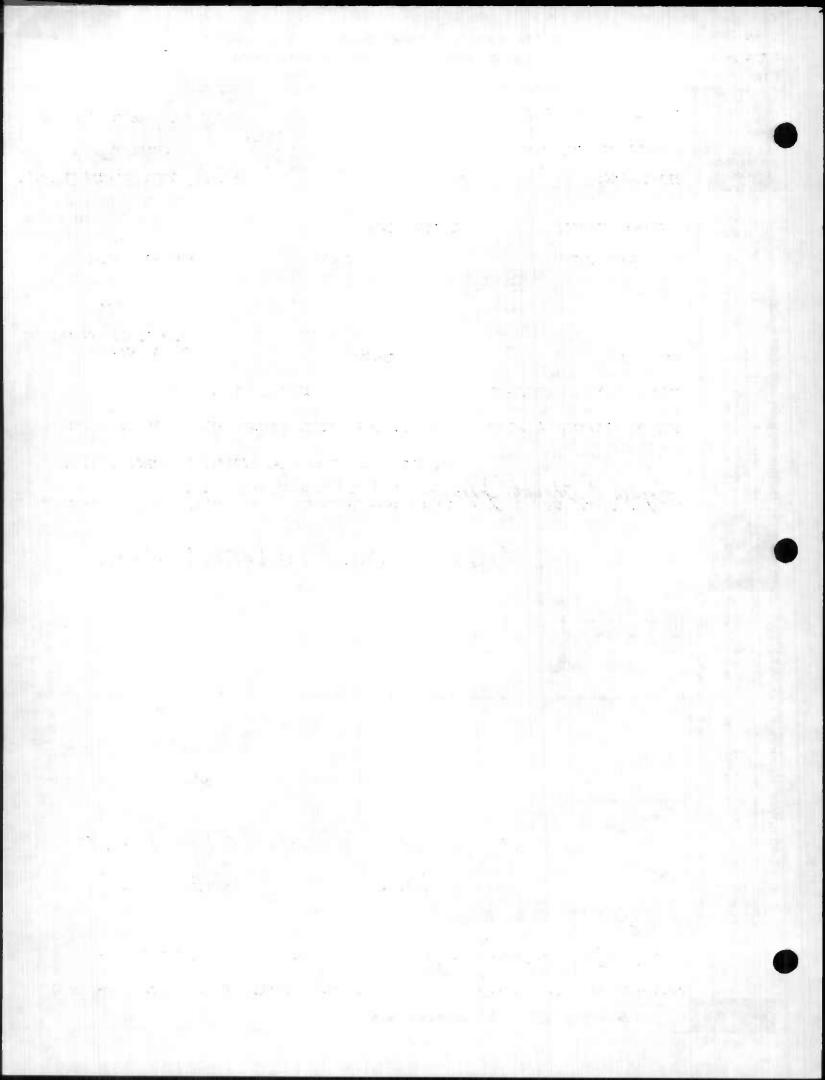
-LARON

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Louff,

mo 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

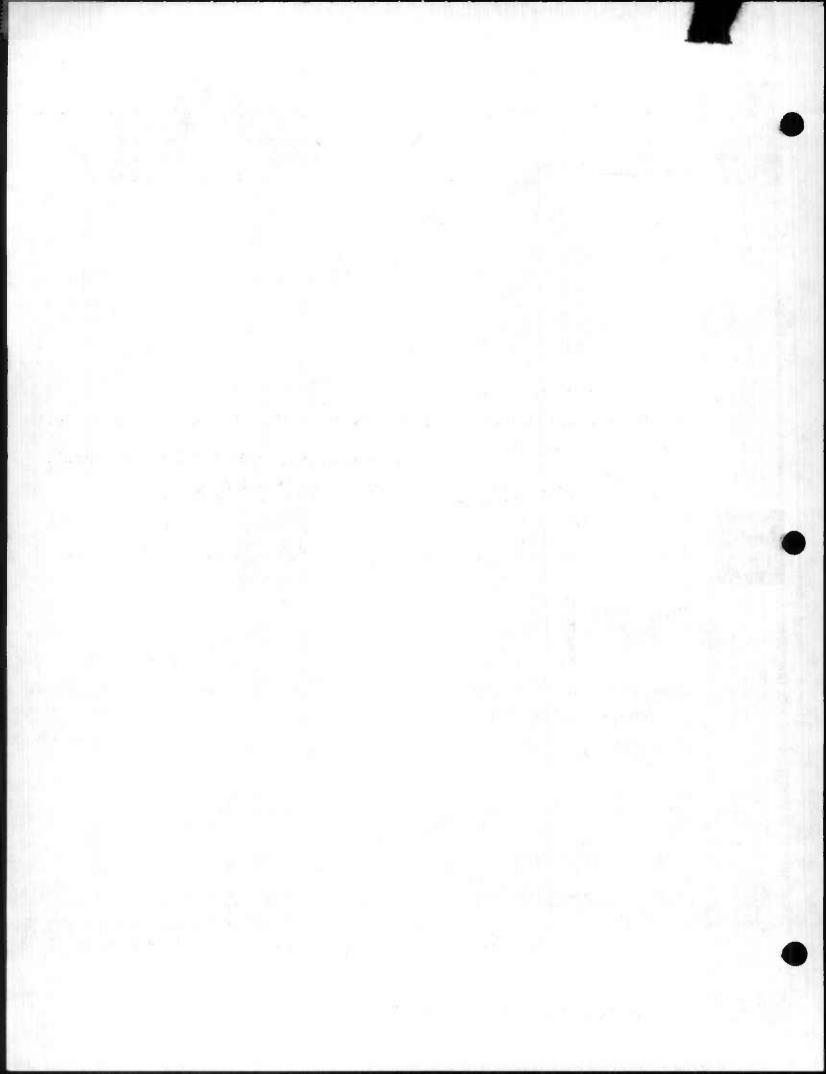
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State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificat	e of	Death			Reg. No.			
			1. Decedent's Nama (First, Middle	e, Last)							2. Date of De	eath		3. Time of Death	
	Physic		Eddie Davis	Washing	rton						Month March	Day 1.6	Year 1998	06.22	
N.	/Medi Exami		4a. Facility Nama (If not institution						4b. City, To		ocation of Deat		ty of Deeth	06;23 an	
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	Funeral		5. Sportal Secority Number 07		Aga (In yrs. las	t birthday)	If Under				8. Date of Bir (Month, De	rth Noorl	9. Birthp	placa (Stete or Foreign	
	Director		442-14-9707	1 🔀 M 2 🗆 F	71	Yrs.	Months	Days	Hours	Min.	April	5, 1926	Alab	ama	
	D .	1	Usual Residence of Decedent		10.00										
	show	-	10a. State 10b. County	6 7	10c. City, 1		cation						1	IOd. Inalde City Limits	
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	igh of	Directo	10e. Street and Number	- a ou-			10f. Zip		0.40		-	10g. Citizen o		ntry?	
	ath v	rai	613 Sorrelwo						040				S.A.		
	er de	Funeral	11. Marital Status	12. Was Decede Armed Forca	is?	13.	Was Deced f Yes, spec	dant of I	Hispanic Ori san, Maxicar	gin? (Sp 1, Puarto	ecify Yas or No Rican, etc.)		ace - Americ ack, Whita,		
20	d within 72 hours efter death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Madical Exerciser must be notified at	by F	1 Nevar Marrled 2 Marr 3 Widowed 4 Divorced	If Yes Give	่		1 🗆 Yes	2 X No	Specify:			Spec	ify: Bl	ack	
21215-0020	hou	Pa	15. Decedent		1		dent's Usua	al Occur	nation			16b. Kind of			
5	C * 6	Completed	(Specify only highes	t grade completed)		(Give	kind of wo	rk done	during mos	t of work	ing	TOD. KING OF	Duantoaann	dustry	
7 7	filed within Hygiene. other than "	E	Elementary/Secondery (0-12)	College (1-4d	or 5+)	Mili						U.S.	Army		
0	高支電点	Be C	17. Fathar's Nama (First, Middle,	Lest)					18. Mothe	r's Nam	e (First, Middle	, Maiden Sume	me)		
maryland		To B	George Washin	ngton						Emr	na Rose				
		-	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street	t end Numbe	er or Rui	ral Route Numb	er, City or Tow	n, Stete, Zip	Code)	
Ž	D = N =		Mrs. Hatsuko T	. Washingto					lwood		_	wood, M	_		
ย์	f Health frem 27 I		20a. Method of Disposition		0.000	e of Dispo	sition (Ner	ne of	200		Date	20c. Location	- City or To	own, State	
5	Pege ent o nt: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	al Cem	,	3/23/98	Arling	ton.	Virginia						
baltimore,	permit. Peges 1 and Department of Healt Important: If Item 2: any Injury or other once.		21. Signature of Funeral Servica		, ALL	22	. Nama an	d Addre	ass of Facilit	v	3/23/98 Arlington, Virginia				
ŏ	Depar Impor any Ir		1	+ R D			Tarri	nq-(Cargo , Mary	Fune	eral Ho	me, P.A 1-3399	•		
			23a Part 1 Enter the disease or	complications that caus	sed the death									Approximate	
	Physician		23a. Part1. Entar tha diseasa, or shock, or heart fellure. List	only one cause on each	n line.									Interval Between Onsat and Death	
	/Medical		Immediate Cause (Final	P	1 1 1		U				6.3.	~	-	0.	
	Examiner		disease or condition resulting in deeth)	a. Re	16451			ct.	Raid	۲L	LNI A	Rello	U	Sec	
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	certificate be axecuted ding physician and ise as the buriel-transit	Examiner	b												
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00/00	certificate be axecuted ding physician and ise as the bunel-transit	//Medicai	that initiated events	С	Due to (or as	a consed	uence of):						-		
3	g ph as th	Ped	resulting in death) Last												
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	requires that the deeth been signed by the atter should be detached for u	Physician	Part II. Other significant conditio	ns contributing to death	but not resulting	a in the u	nderivina c	ause di	ven in Part I		23b. Dld	tobacco use c	ontribute to	the cause of death?	
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or vital necenas,	v require been sig should t		-CHF	1101							24a. Was	an autopsy		ere autopsy findings allable prior to	
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U		BeC	25. Wes case referred to medical						26. Place	of Deat	h (Check only			2.00 20.00	
>		To B	examiner? 1∕∆ Yes 2 No	Hoapital:	atient 2□ER	/Outpatien	1 32 DC	A Ott	her		ome 5 ☐ Resi		ther (Specif	(v)	
			27. Manner of Deeth	28a. Date of Ir	njury 28	b. Time of		8c. Inju				how injury occu		,,	
Division	Attanding Firdeath. • Ctor: Aftar by the funer	atio	1 Netural 5 Pending		Dey Year)	Injury	- м		rk≀ Yes 2∐	No					
2	or Attandi aftar death Director: A d in by the f	Fic	3 ☐ Suicida 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	injury - At home	, farm, str	eet, factory	, office					nber or Rura	I Route Number,	
5	S affa	Certification:	4 Nothicide	building,	etc. (Specify)				~		City or To	wn, Stera)			
	To the Hospital or Att within 24 hours aftar of To the Funeral Direct completely filled in by		29a. Certifiar 1 Certifying	Phyalcian: To the be	st of my knowled	dge, death	occurred	at the th	me, date an	d placa,	and due to the	cause(s) end r	nenner as s	teted.	
	the He hin 24 the Fu	edical	(Check only one) 2 Medical E	xaminer: On the besis and manner	of examination stated.	and/or inv	estigation,	In my c	opinion, deal	th occur	red at the time,	dete and place	, and due to	the ceuse(s)	
	To the comple	Σ										ed (Month,	Dey, Year)		
			m	12m 4	m?			0	1421	-5		3.0	16-	78	
	1/8/		30. Name and address of person v	who completed cause of	f death (Item 23	ia) (Type.	Print)							- 0	
	7.7		The same of the sa			21 76 -1									
	Sta	te	31. Date filed (Month, Day, Yeer)	32: Flegis	strar's Signature	0 .	.4								
	Regist		MAR 1-81	998 Jun	strar's Signature	hardal	4								

Washington



RNELL WAI	LKER	State of Marylar	•	nent of H		Mental Hy	/giene Reg. No.	10232
Dhysician	1. Decedent'a Name (First, Middle, Las	st)				2. Date of D Month	eath Day	3. Time of Dea
Physician /Medical	DONNELL ANTONIO 4a Facility Name (If not institution, giv.				b. Citv. Town, o	MARCH r Location of Dea	14, 19	98 3:15A.M
Examiner	1221 BENNING ROAD	a stront and manually			APITOL		1	GEORGES
Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs.		Under 1 Year	If Under 24 Hr	s. 8. Date of B		
Director	579-80-9735 Usual Residence of Decedent	XXM 2□F 26	Yrs. Mo	nths Days	Hours Mir	OCTOBEL	31,197	9. Birthplace (State or For Country) WASHINGTON
death with the Maryland rms 23a or 28a-f show rms ba notified neral Director	10a. Stata 10b. County	10c. Ci	ty, Town or Locatio	n				10d. Inside City Li
e Ma	MD PRINCE	GEORGES	TEMPLE H					1X Yas 2
or 2	10e. Street and Number			Of. Zip Coda			10g. Citizen of V	Vhat Country?
ath w	4617 DALLAS PL.			20748			USA	
	11. Marital Status 1 Never Married 2 Married	12. Was Decedant Ever in U Armed Forcas? 1 ☐ Yas 2 ☑ No				Specify Yes or Norto Rican, etc.)	Biad	e - American Indian, k, White, etc.
72 hours after natural; or its sical Examina	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10,	res 21 No	Specify:		Specify	BLACK
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should be not marked marked marked	19a. Informant's Name/Relationship (Tune Print)	19h Malling A	idraes (Street			ber, City or Town,	Stata Zin Code)
s 1 and 2 should f Health end Mer tem 27 is marke other traumatic	GWENDOLYN WALKER						MD APT 2	
of Heal	20a. Method of Disposition	20b.	Place of Disposition	(Name of		Date	T	City or Town, State
age anto y or	1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5	Removal from Stata	cemetery, cremator ETROPOLIT			3-21-98	ALEXAN	DRIA VIRGINI
permit. Page Department of Important: If any Injury or once.	21. Signature of Funaral Sarvice Licer		22. Na	ma and Addre	ss of Facility	1	1	
Depa Impo any t	Jaron L	()	ALE 5538	XANDER	S. POPI	E FUNERA	L HOMES VILLE MD	20747
Physician /Medical Examiner	Immediata Causa (Final disaase or condition resulting In death)	a. Stab W Due to (or as a consequent		Chast	-		
be executed ician and buriel-transit		b. Due to (or as a consequent	ca of):				1
e sy e	that initiated events	Dua to (d	or as a consequent	ea of):				
death de atten					To be Board	anh Di	d Anhanna ann an	ntributa to the cause of de
thet the death ed by the atte detached for Physicia	Part II. Other significant conditions of	ontributing to death but not re-	suiting in the under	lying cause giv	en in Part I.		Yee 2 No	3 Probably 4 Unk
The lew requires that the death certifice tale has been signed by the attending phyage 2 should be detached for use as it completed by Physician/Med							s an autopsy tormed?	24b. Were autopsy findi available prior to
hes be ga 2 sh	-					-		completion of caus of death?
certificate he rector, paga						•	Yes 2□No	1 Yes 2□ No
Physician: this certific ral director, To Be		Hospital:	3500	Oth	101:	leath (Check only		
Physic rthis o rail dire		1 ☐ inpatient 2 ☐	28b. Time of	28c. Injur	4 - Idniging	Homa 5 ☐ Re 28d. Describ	how injury occur	er (Specify) Scane
tal or Attending P is after dasth. Is Director: After t led in by the funers Certification:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	0215		rk? Yes 2⊠No	Sub	icet SI	ribbed
Attendi	3 Sulcide 6 Could not b	6 SOS Dises of lains. At h	0,	factory, offica				per or Rurel Routa Number
Direct din L	4 PHomicide determined	building, etc. (Special Control of Control o	Lence			1221	Benni)	a Rel
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge death occ	urred at the tir gation, in my o	me, date and pla opinion, death oc	ce, and due to the	e cause(s) and mi	anner as stated. and due to the cause(s)
o the complete of the complete		101		29c. Licens	e number		29d. Date signe	d (Month, Day, Year)
-340	•	4741		0.0	C.M.E.		MARCH 14	1,1998
1)	30. Name end address of person who	completed cause of death (ite						
	1 1 1	Forle	1	11 Don	Ctronot	Poltir	Mar	land 21201
	Hund K	force	1	II Pell	Street	., partn	iore, har	ryland 21201

DHMH 16 Rev 6/95



The state of

	1. Decedant's Na	ma (First, Middla, Le	ist)		Certifica	A10 01	Dealii	2. Data of D	Reg. No.	- 1	3. Time of Death		
lclan dical	CHELNI			IS				Marc	L, 16	1498	4:18 P		
niner	4a. Facility Nama	(If not institution, gi	va street and number)			9	4b. City, Town, or	Location of Dea	ath 4c. Cou	nty of Death			
al	STELLA 5. Social Sacurity unknown Usual Rasidance	Numbar 6. S	MERCY HOSP Sax 1□ M 2□X 82	a (In yrs. last birt	thday) If Uni Month	dar 1 Yaar	Baltimor If Undar 24 Hrs Hours Mir	s. 8. Data of B (Month, L	land lith Dey, Year) 11, 191	Balti 9. Birthr Cour 6 Libe	placa (Stata or Fore		
	10a. Stata	10b. County		10c. City, Town	or Location					1	I Od. Inside City Lin		
Director	Manueland	Baltime	ore	Dolada.							X Yas 2		
Director	Maryland 10e. Street and N			Baltim		Zip Code			10g. Citizan o	of What Cour	ntry?		
a D	2728 Sai	nt Paul S	treet		2	1218			Liber	ia			
Funerai	11. Marital Status		12. Was Dacedant B	Evar In U,S.	13. Was De	cedant of h	lispanic Origin? (Specify Yas or N	lo- 14. R	aca - Amario			
þ		rriad 2 Married 4 Divorced	Armed Forces? 1 Yes 2 N If Yas, Giva Yaar or Datas:	ło		2 XN0	Specify:	no moan, aro.,		oity: Libe			
Completed	(Spi	15. Decedant's E ecify only highast gro	ducation eda com <i>plated)</i> College (1-4or 5		Decedent's U (Giva kind of lifa. DO NO	work dona	duning most of wa	orking	16b. Kind of	Businass/In	dustry		
Be Con	8th	grade (First, Middla, Last			ck Disp	patch		eme (First, Middl			vernment		
To E	Jeremiah	Scott					Virgini	a Brown	ell Sco	tt			
1.	19a. Informant's I	Name/Ralationship (Typa, Print)	19b.	Mailing Addre	ass (Streat	and Number or F	lure/ Routa Num	ber, City or Tox	vn, Steta, Zip	Code)		
	1 Burial	sposition	, Daughter Removal from Stata	20b. Place of cematar	y, cramatory o	rotnar pia		28 Mar	more, M 20c. Locatio 98 Spring				
9000	21. Signature of F	uneral Service Licer	1500 B.	Gate o				ohnson	& Jenki	ns Inc			
	23a. Part1. Englishook, or ha	the disease, or comert failure. List only	plications that caused one muse on aech lin	tha daath. Do n	ot antar tha m	oda of dylr	ng, such es cardia	ac or raspiratory	arrest,	T	Approximete Interval Batween		
n	/		3.72	0							Onset and Death		
al er	Immediata Causa disaasa or condit	on	a	15 cm	~	1	to not y	nses		i	1 manh		
	rasoking in door	Immediata Causa (Finel disaasa or condition rasulting in deeth) Due to (or as a consequence of): Methytheth Caree b. Methytheth Caree											
Examiner	6. Methylota Greast Care												
Exa	Sequentially list conditions, if any, laading to Immadiata causa. Enter Undarfying Causa (Disaasa or injury c.												
edical	mat initiated aven	ts .	C	Dua to (or as a c	onsaguance o	f):		· · · · · · · · · · · · · · · · · · ·					
Physician/M			d										
ysic	Part It. Other sign	ificant conditions o	ontributing to death bu	it not rasulting in	tha undarlying	g causa giv	an in Part I.	23b. Did	d tobacco use	contribute to	the cause of de		
								1	1408 30 No	3 □ Proi	bably 4 ☐ Unki		
Completed by									s an autopsy formed?	av	ara autopsy findin aitabla prior to mplation of causa deeth?		
E								1□	Yas 20No	10	Yas 2□No		
Be	25. Was case refe	rred to medical					26. Place of De	ath (Check only	one) STEL		RIS AT ME		
2	27. Manne of Das 1 Natural	5 Panding	Hospitel: 1 ☐ Inpatier 28a. Data of Injur (Month, Day	y. 28b. T		28c. Injur Wor	ar: 4□ Nursing l y at k?	Homa 5 ☐ Res		thar (Specif	y) HOSPICE		
Certification:	3 ☐ Suicide 4 ☐ Homicide	Invastigation 6 Could not be determined					Yes 2 □ No	28f. Location City or To	(Street and Num own, Steta)	m <i>ber</i> or Rura	il Route Number,		
edicai C	29a. Certifiar (Check only one)	Certifying Ph	yalcian: To the best of niner: On the basis of and mannar stat	axamination and	daath occurre Vor Invastigati	ed at tha tir on, in my o	ne, dete and plac pinion, death occ	a, end dua to the urred at tha tima	a causa(s) and , data and plac	mannar as s a, and dua to	teted. o the cause(s)		
Me	29b. Signatura an	d titla of certifier	^		2	9c. Licans	a number		29d. Data sig	ned (Month,	Day, Year)		
	► der	MIL	~}~			PU	0854		3/	16/1	K		
	30. Neime and edd	ress of person who	complated cause of de	ath (Item 23a) (Type Print)		191	BMJ	_				

Registrar DHMH 16 Rev 6/95

WILLIAMS, CHELNISIA

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene 9 8

					C	ertificate of	f Death		Re	g. No.		0204	
		U	1. Decedent's Name (First, Middle, La	st)				1	2. Date of Death	h Day	Year	3. Time of Death	
	Physici /Medic		LEONARD ALFRE	D WASHI	NGTON				MARCH		1998	4:00AM	
	Examir		4a. Facility Name (If not institution, giv	a street and number)			4b. City, To	own, or Loca	ation of Death	4c. County	y of Death		
			4900 WHEELER F				OXON			PRINCE			
	Funeral Director		5. Social Security Number 6. S 288–30–1531 Usual Residence of Decedent	ex 7. Age	(In yrs. last birthd	Months Days		Min.	B. Date of Birth (Month, Day, PRIL 8			place (Stete or Foreign ntry) ELAND, OH.	
	hend we		10a. Stata 10b. County		10c. City, Town o	r Location						10d. inside City Limits	
	the Mery 28a-1 sh notified	Director	MARYLAND PRINCE (GEORGE'S	OXON	HILL 10f. Zip Coda			10	og. Citizen of	What Cou	1 Yes 2 No	
	seth with		4900 WHEELER RD.	40 Man Danadani Fr	or la II S	207	45	lain? (Spec		UNITEI) STA	_21	
21215-0020	is 1 and 2 should be filed within 72 hours after death with the Meryland of Health and Mental hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprisor must be notified at	d by Funeral	11. Marilai Status 1 □ Navar Married 2 ☑ Marriad 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No	4/23/62 4/22/66	13. Was Decedant of if Yas, specify Cu 1 ☐ Yes 2 ☐ No			icen, etc.)		etc.		
5-0	72 h netu	etec	15. Dacedant's Education (Specify only highest gra	ducation de completed)	(G	ecedent's Usual Occi	e during mos	st of working	,	16b. Kind of B	lusiness/In	ndustry	
2121	filed within Hygiene. ther than ent, the We	Completed	Elamantary/Sacondary (0-12)	College (1-4or 5+	1	e. DO NOT use ratir T MANAGEM		ONTROI		PRIVA	ATE		
	be filed ital Hygi d other event, I	Be C	17. Faihar's Name (First, Middla, Last,				18. Moth	er's Name ((First, Middle, M	faiden Sumer	me)		
yla	should be and Mental is marked o	To	CHARLES WASHING	TON			ANN	NA L	FOLS	TON			
, Maryland	Health and Health and Health and Health and 27 is matcher trauma		19a. Informant's Name/Raiationship (ETHELENE WASHIM	Type, Print) IGTON/WIFE		ailing Address (Street						0745	
Baltimore,	ant of the your		20a. Method of Disposition 1 □ Burial 2 ☑ Cramation 3 □ 4 □ Donation 5 □ Other (Specif		cemetery,	sposition (Nema of cremetory or other plants)		3/		20c. Location			
Balti	permit. Pe Departmen important: any injury once.		ARLINGTON NATIONAL 3/25/98 ARLINGTON, 21. Signature of Funeral Service Licenses ARLINGTON NATIONAL 3/25/98 ARLINGTON, 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MD.										
	10110		Neith C. De	wec _		5538 MA	RLBORO	PIKE	E/FORES	CVILLE,	MD.	20747	
			23a. Part1. Entar Iha disaase, or com shock, or heart failure. List only	plications that caused to one cause on each line	na daaih. Do not).	antar tha moda of dy	ying, such as	s cardiac or	respiratory arre	est,	1	Approximate interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final	A	Can	5 . O M		. 1		,		-	
	Examiner		disease or condition resulting in death)		ue to (or as a cor	DIOPULM	ONAKY	/1	KKES 1		- 14	25 min	
_		ner		. END	STAG.	c PANCI	OCAT.	1,-	CANC	0		7 18 months	
	nd nd transi	Examiner	Sequentially list conditions,		ue to (or as a cor	,	CAL		C/1/VC		1	10 1110111	
90,	oe exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury	C									
68760,	law requires that the death certificate be executed as been signed by the attending physician end as been signed by the attending physician end as Should be deteched for use as the bunal-transit	ledicai	that initiated avents resulting in death) Last	Di	ue to (or as a con	sequence of):							
Box	attending p	an/M		d							1		
	the att	sici	Part II. Other significant conditions of	ontributing to death but	not resulting in th	e underlying causa (givan In Part	1.	23b. Did to	bacco use co	ontribute t	to the cause of death?	
, P.O.	es that the de	by Physician/	INSULIN DE	ERENDENT	- Di	ABETES	MELL	ITUS	1 □ Y	s 2□No	3 ☐ Pro	obably 4 Unknown	
rds	v requires been sign should be	ed by	,,,,,						24a. Was a	n autopsy		Vere autopsy findings vailable prior to	
of Vital Records,	has bee	Completed		_					periori	lied!	C	ompletion of causa f death?	
- H	The ate h	Con							1 □ Ye	s 2 No	1	☐ Yes 2☐ No	
/ita	Physician: The rthis certificate rai director, pag	Be	25. Was cese referred to medicei examiner?					e of Death	(Check only on	e)			
of \	physic this o	P	1 ☐ Yes 2 ☑ No	Hospital:		Ment 3LI DOA			e 512 Reside			ify)	
	After funer	ion:	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Dey	Year) 28b. Tim Inju	ry W	juryat /ork? □Yes 2□		8d. Dascribe ho	w Injury occu	rred		
Division	Attending or deeth.	ficat	2 Accident investigation 3 Suicida 6 Could not be determined	9 Ogo Diogo of Injure	v - At home, farm	, street, factory, office			8f. Location (St	reet end Num	ber or Rui	ral Route Number,	
D.	after Dire	Certification:	4 Homicide determined	building, atc.	(Spacify)	, , , ,			City or Town	n, Stete)			
	To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	edicai C	29a. Cartifier 1 Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of a and manner state	xamination and/o	aath occurrad at tha ir Invastigation, in my	tima, data a opinion, da	nd place, ar ath occurre	nd due to tha ca d at the time, da	ause(s) and mate and place,	annar as : , and dua !	statad. to the cause(s)	
	To the To the	Me	29b. Signature and title of certifier		4	29c. Lice	nse number		2	9d. Date signe	ed (Month	, Dey, Year)	
			> Xm	Palile	4.1	D. D5	068	6		3/13.	198		
	(4)		30. Nama and addrass of person who	1	ath (item 23a) (Ty	pe, Print)				1-/			
	()		SHAKUN MUNSHI				NS/N	AV	E 5	VITE	103	BETHER	
	Sta Registr		31. Date flied (Month, Day, Yeer) MAR 1 6 199	8 Subjection	's Signature	Lit							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death 3 9 9 9 8 ey **Physician** 4:04 P.M MARY A. WOMACK /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, giva street and number) 4c. County of Deeth Examiner Cheverly Prince George's Hospital Center Prince George's If Under 1 Yaar 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Social Sacurity Number **Funeral** 1□M 2⊠F Months Deys Hours Min 65 230-40-2475 Chatham, **Director** 2/20/33 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or itema 23a or 28a-f show traumatic avent, the Modical Examinat must be notified at 1 Yas 2 No DC Washington Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 3976 East Capitol Street, N.E. 20019 USA permit. Peges 1 end 2 should be filed within 72 hours after deeth a Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or itema 23a any injury or other traumatic avent, its Medical Example once. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Merital Stetus Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: by 3 □Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) L.P.N. - DC General Hosp. Hospital 12 18. Mother's Neme (First, Middle, Meiden Sumema) 17. Fether's Name (First, Middla, Last) Mary Fitzgerald UNKNOWN 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7421 Taylor Street Landover Hills, MD Delores F. Green/Cousin 20785 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Park 3/16/98 1 Burlal 2 Cramation 3 Removel from State Landover, MD Harmony Memorial & Other (Specify) 4 Donetion 22. Neme end Address of Facility Henry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Ave., N.E 21. Signeture of Funeral Service Lice Washington, DC 20019

Part Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List on one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner physician and the bunal-transit Sequentially list conditions, if any, laeding to Immadiate cause. Enter Underlying Cause (Disaase or injury thet initiated events resulting in deeth) Last attanding pl ces ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to completion of cause of deeth? should b Completed 24e. Wes en eutopsy performed? is certificata hes director, page 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) #105/11-6 10 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Mannes of Deeth 28b. Time of 28c. Injury et Work? Affer 1 DiNetural 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: deeth. ector: A the Funeral Direction of the Funeral Direction Hospital within 24 hor To the Fune completely fi

with the Maryland

Baltimore, Maryland 21215-0020

Certification: edicai

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end mennar as steted.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, data and pleca, and due to the cause(s) and menner stated.

29b. Signeture and title of certif dic. muse

29c. Licanse number 29d. Dete signed (Month, Day, Year) D31528 11, 1998 MARCH

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

AKPAN MARGARET DODGE PARIL RD. LANDOVER MD. 20785 3308 31. Dete filed (Month, Dey, Year)

State Registrar

Registrer's Signetur MAR 1 6 75





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ZORANSKI 3:55 PM OROTH MARCH /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) Montgomery 7. Age (In yrs. last birthday) If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country)

Virginia **Funeral** Deys Hours 1□M 21 F 225-22-3166 Yrs. 74 Director 1923 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avent, the Modical Examinat must be notified as 10d. Inside City Limits Director Prince Georges 1 No 2 No College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 6818 Westchester Park Drive 20740 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 □ Divorced Specify: Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Government / Federal Elementery/Secondary (0-12) College (1-4or 5+) Secretary 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be unobtainable unobtainble 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Demetra Mandis/Daughter 318 Prince Street, Alexandria, VA 22314 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20a. Melhod of Disg 20c. Location - City or Town, State 1 ABurial oval from State Cremation 3 [Z/R/ Gate of Heaven 3/19/98 Silver Spring, MD 4 Donat 5 Other (Specify e of Funeral Service L Name end Address of Fecility Hines-Rinaldi Funeral Home, 11800 New Hampshire Evenue, Silver Spring, MD 20904 Part. Enter the disease, or complications that caused to shock, or heart feilure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner ulm ony Examiner requires that the death certificate be executed bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest pue P.O. Box 68760, ettending physician for use es the buria Physician/Medical Due to (or as a consequence of) ed by the ed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? robably 4 Unknown 1 Yes 2 No 31 been signed be should be deta Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed hes page 2 this certificata 1 Tyes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral idrector, is 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA Dutient 27 Menner of Pine (Month, Dey 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation atural 1 Yes 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical ertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.

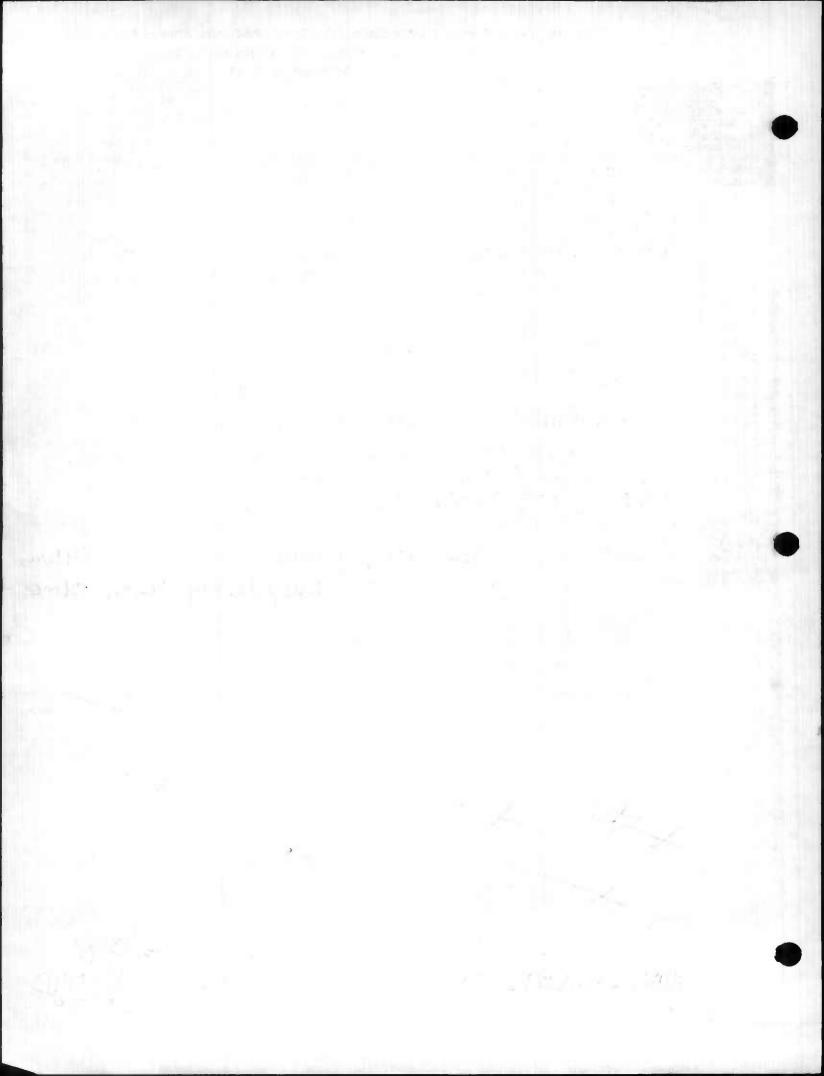
| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner slated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Dey, Yeer)

State Registrar

31. Date filed (Month, Day, Year)
MAR 16 1998

32 Registrar's Signature
Super Davidson Randolle

Franklit MI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:50 PM March 26 JOAN DORIS AUSTIN 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HOSPITAL Arundel GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) LONDON, ENGLAND 8. Date of Birth (Month, Dey, Yeer) Hours 1□ M 2♥ F 212-23-0954 Yrs. MARCH 31, 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED KINGDOM 21061 859 BRIGHTON PLACE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2√ No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementery/Secondery (0-12) 12 QUALITY CONTROL KODAK 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) FLORENCE CLARA TAYLOR FREDERICK CHARLES WATTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 859 BRIGHTON PLACE GLEN BURNIE, MARYLAND 21061 LINDA DUNCAN-DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK3/31/98 GLEN BURNIE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A. GLEN BURNIE, MARYLAND 21061 1 SECOND AVE., S.W. 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset and Death . Septic Shock Immediate Cause (Final disease or condition resulting in death) Perforation

Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that intileted events resulting in death) Last Paucreatic Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1Ă inpatient 2☐ ER/Outpatient 3☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident

Examiner Box 68760 P.0. Records, Division of Vital after deeth.

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Physician

/Medical

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Certification:

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3 Suicide

29a. Certifier

4 Homicide

Funeral

Director

I is marked other than "natural", or items 23s or 28s-1 show traumstic evant, the Medical Examiner must be notified at

Deperment of Health and Mental thygiene. Important: If Item 27 is marked other than "natural", or Itema 23a any Injury or other traumatic event, the Medical Examination

Physician /Medical

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signed be del

2 should be f end Mental It

Registrar

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12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number

29d. Date signed (Month, Dey, Year) March, 26, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Ham 230) (Type, Print)

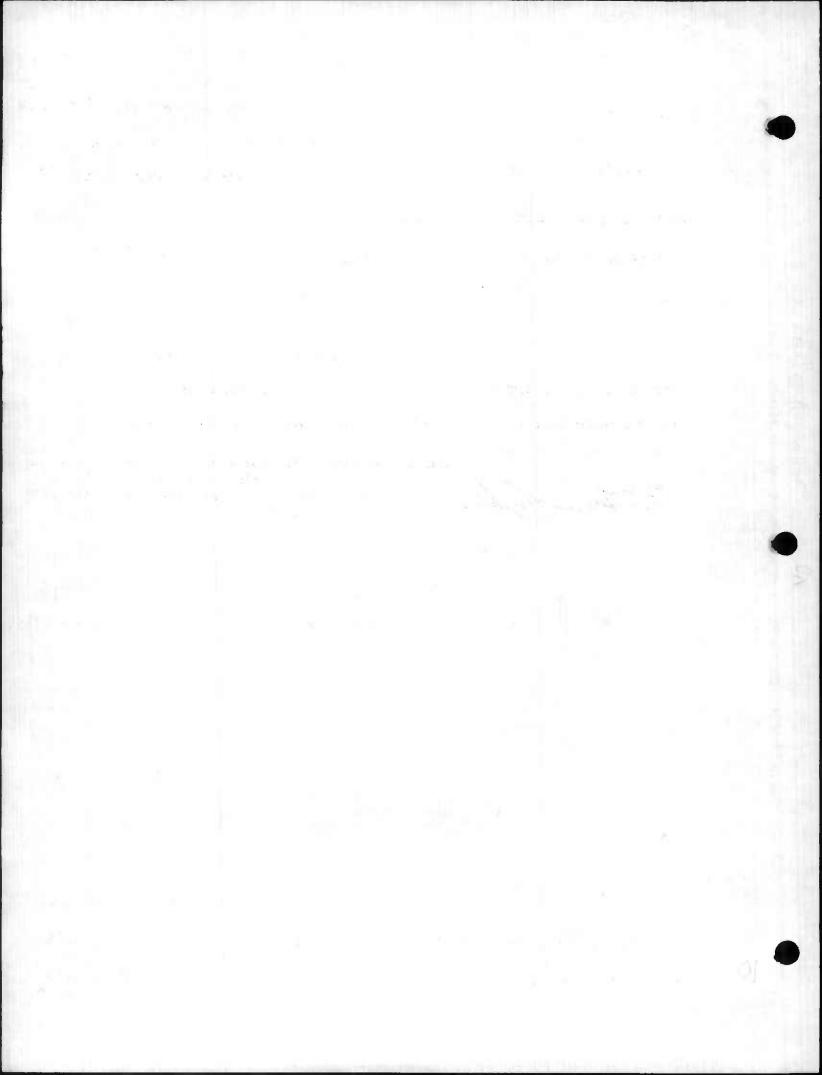
Sherib E195521 North Arundal Hospital 301 Hospital Drive Glen Burnie, MD
21061

31. Date filed (Month, Dey, Year)

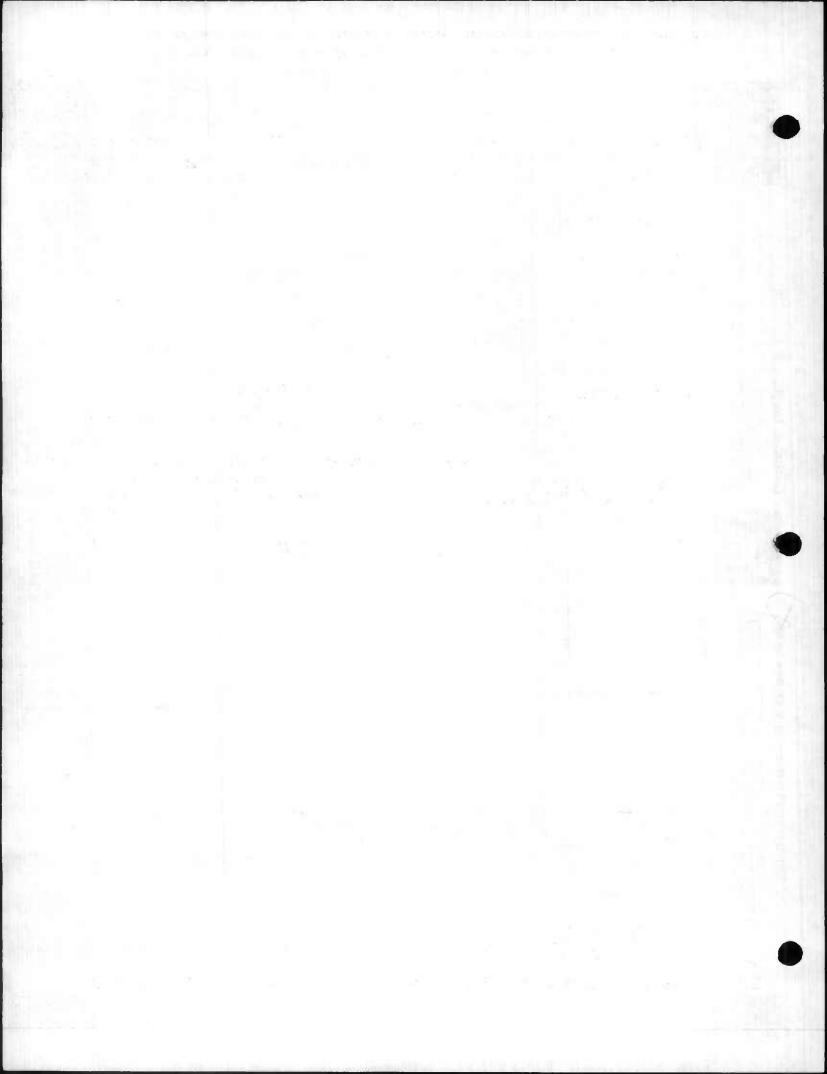
29b. Signature and title of certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



				State of	Marylan		rtment tificate			Mental H	ygiene Reg. No. 9	3 [0238		
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o o	Physici /Medic		ELISABETH TRIMB	LE ARKUS	SZESKI					MARCH	29 1	Yeer	8:15AM		
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	deat	Funeral	11. Maritel Status	12. Was Dece Armed For	dent Ever In U	S. 13. V	Vas Deceder	nt of H	lispenic Origin?	(Specify Yes or Nerto Rican, etc.)	o- 14. Re		ican Indien,		
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Baltimore,	permit. Pages Depertment of I Important: If ite any injury or of									1	SINGLETON FUNERAL HOME, P. A				
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	Sta Registr		31. Dete filed (Month, Dey, Year) APR 0 1		gistrar's Signe Julia Day		indell								



State of Maryland / Department of Health and Mental Hygiene S Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** March 28, 1998 Jean Brune1 11:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Montgomery General Hospital Montgomery 01ney 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 ₩ F 1921 Pennsylvania 577-18-9071 Aug. 22, 76 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Prince Georges Riverdale Directo 2 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or items 23s or the Medical Examinar must be. 6004 Rhode Island Avenue 20737 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Yas 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Speech Therapist School School mericed other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be the ment of Health and Mental H lant: If Nem 27 is merked off Jury or other traumatic even 88 Ian Forbes Sarah Grace Crawford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gordon Gregory Brigham/son 6004 Rhode Island Avenue, Riverdale, Maryland 20737 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stata 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Department of Important: If any injury or 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ronald S. Wade Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Baltimore, Maryland 21201

anti. Enter the disease, or complications that ceused the death. Do not anter tha mode of dying, such as cerdiac or respiretory arrest, hock, or heart feilure. List only ona ceusa on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Wee disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner physician and s the burial-trensit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): attending pl Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the bed signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of ceuse of death? been si 24a. Was an autopsy Completed certificate has t The 20 No 1 Yes 1 ☐ Yes 2 ☐ No al or Attending Physician: T s efter death. Il Director: After this certificat ed in by the funeral director, p 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not ba determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) end menner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifian 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23a) (Type Pint) llip Dr, Suite 212, Olvey

State Registrar

APR 0 1 1998

31. Date filed (Month, Day, Year)

32. Registrer's Signeture Jula Davidson Bondall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item 1 Per PHY Film G761 7-14-98 rjaState of Maryland / Department of Health and Mental Hygiene 8 Amend: #1 Per MD Film G761 7-2-98RC Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 3 **Physician** 0004 DANIE mars 26 /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER 5. Social Security Number 214-38-4213 If Undar 1 Yeer | If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 180 M 2□ F Months Days Hours Yrs 57 22, 1940 BALTIMORE, Director Usual Rasidance of Decedant permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or harm no other traumett. 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ANNE ARUNDEL SEVERNA PARK 1 Yas 2 No MARYLAND Directo 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 35 KLEIS ROAD 21146 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14 Rece - American Indian 11. Merital Status Bleck, Whita, at 1 ∑ Yas 2 ☐ No If Yas, Giva Yeer or Datas: 1 Navar Married Marriad 1 Yas 2 No WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work dona during most of working life. DO NOT usa retired) Collaga (1-4or 5+) Elementary/Secondary (0-12) CRIMINAL INVESTIGATION LAW ENFORCEMENT 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fethar's Nema (First, Middle, Last) 8 DANIEL A. BONIARSKI, SR. HELEN ANNA TWAROWSKI 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) DANIELLE A. LEPPER-DAUGHTER 111 BONNIE VIEW ROAD GLEN BURNIE, MD 21060 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 XBurial 2 Cramation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY 3/31/98 DUNDALK, MARYLAND 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE., SW GLEN BURNIE, MARYLAND 21061 23a. Part1. Entar the disease, or complications that ceused the death. Do not entar the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intarval Batween Onsat and Death **Physician** HypoVolemic Shoch /Medical Immediata Causa (Final disaasa or condition rasulting in daath) 12 W Examiner ADR tic ANEURYSM Physician/Medical Examiner Sequantially list conditions, if any, laading to immediata ceusa. Enter Undarlying Causa (Disaasa or Injury that kirked areas and Injury) NSION PREUMOTHOR that initiated evants rasulting in death) Last P.O. Box 687 Emphysemotous Bleb 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? complation of ceuse of death? Thermia, - Bleedind iAthesis 2° to MASSIVE 1 ☐ Yas 2 ☐ No \$/000V 25. Was casa rafarred to medical examinar? Be 26. Plece of Daath (Chack only ona) Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) Hospitel:

Inpatiant 2 □ ER/Outpatient 3 □ DOA Yes 2□ No 2 funerel 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred Certification: After 1 Natural 5 Panding 1 Yas 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical completely (Check only one) within 2. To the F 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licanse number

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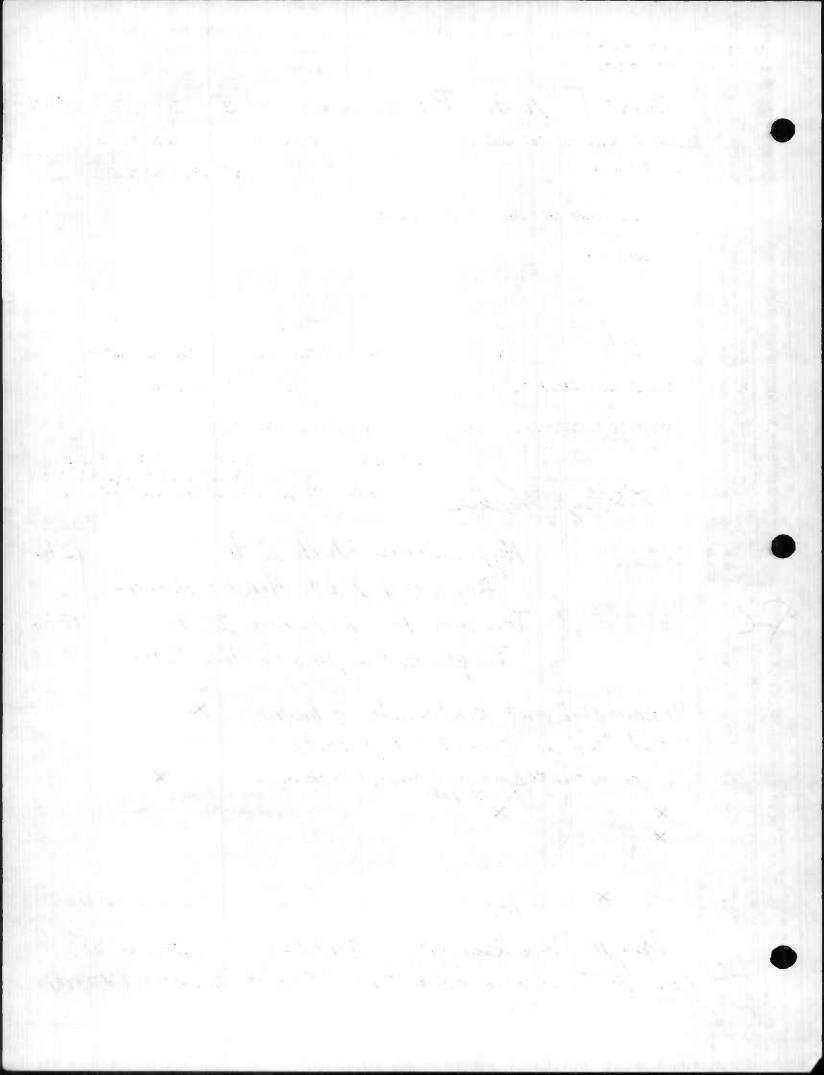
30. Nana and addrass of person who complated causa of deeth (Item 23a) (Type, Print) RichARdson, MDIOH

Forbes

Julia Davidson

Street ANN Apolis Md 21401

31. Dete-filed (Month, Day, Year)



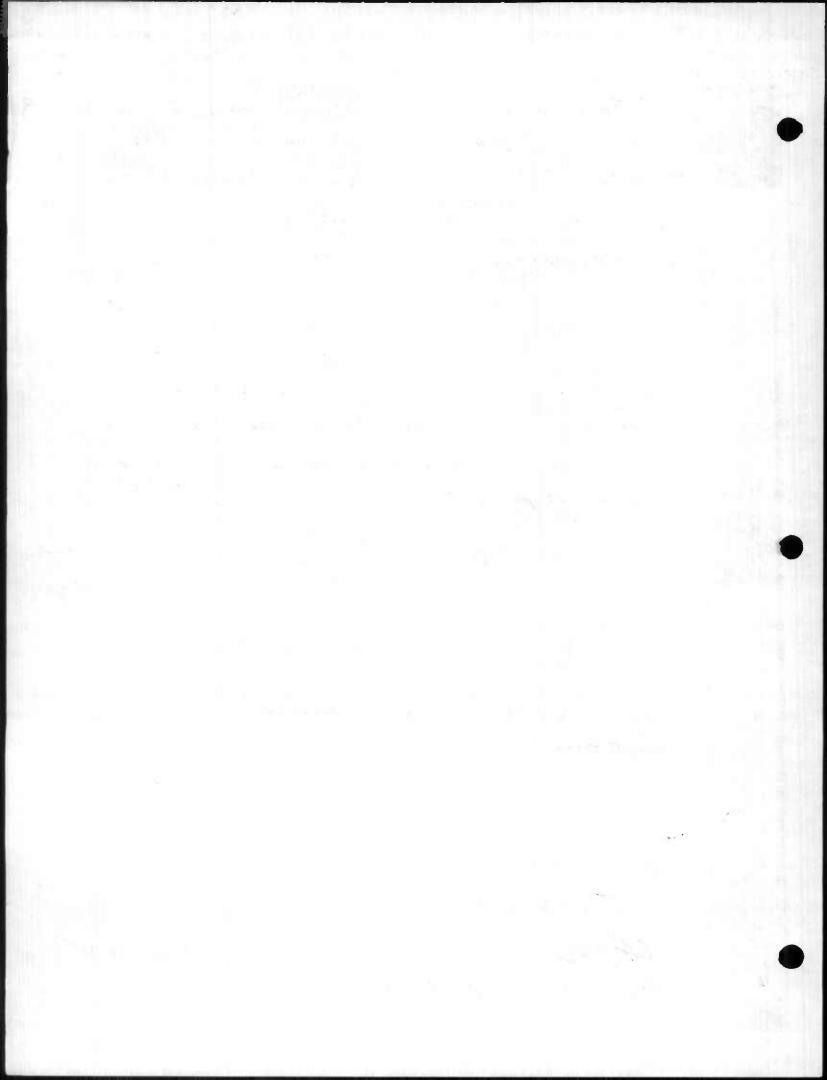
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

_	-				•		Certificate	of Death		Reg. No. 98	102	41
3	Physici	an	1. Decedent's Name (First, Mi		D.	ink:	5		2. Dete of D Month	eath Day	3. T	ime of Death
	/Medi		EV		Marc	n 27	1998 10:00a.m.					
4	Examir	ner	4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Lo 1rvington Nursing Home Baltimore							th 4c. County	of Deeth	
	Funeral Director		5. Social Security Number 217–28–8075	6. Sex 1 ☐ M 2/x		n yrs. lest bir 7	thday) If Under 1 Yrs. Months		lin. (Month, D	rth ey, Year) 22, 1910		Stete or Foreign
	pug *		Usual Residenca of Decedent 10a. Stete 10b. Cou		10c. City, Town or Location							lde Ob il limite
	the Marylar 28a-f show	5		ı/a			ltimore					Side City Limits ByYes 2 □ No
		rect	10e. Street and Number				10f. Zip C	ode		10g. Citizen of		X
	ath with 23a or	Funeral Director	1824 Presstma					21217		USA		
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f show ent, the Madical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Nover Ma	Armid 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Eve ed Forces? Yes 2 No is, Give r or Dates:	r In U,S.	13. Was Deceder		of Hispanic Origin? (Specify Yes or Ni Cuben, Mexican, Puerto Rican, etc.) No Specify:		ce - American Ind ck, White, etc. y: Black	en,
5-0	72 hours "naturel",	etec	15. Deced (Specify only hig	dent's Education ghest grade comple	eted)	160.	Dacedant's Usuel ((Give kind of work	Occupation done during most of i	working	16b. Kind of B	usiness/Industry	
2121	filed within Hygiene. ther then ent, the Me	Completed	Elamantery/Secondary (0-12 5th grade	-	Collage (1-4or 5+)		nestic	retired)	one during most of working trired)		ldstein	
P	should be filed with nd Mentel Hygiene merked other tha imetic event, the	e C	17. Fether's Name (First, Midd					18. Mother's N	Name (First, Middle	, Maiden Sumen	ne)	
/lar		To Be	James Bradley					Martha	a		unknow	n
Maryland	ra la		19a. Informent's Name/Relation Angela McCray	onship (Type, Print	⁹ daught	er 30		Street end Number or SON BLVD.				
e,	- 2 E 4		20e. Method of Disposition		- 2		f Disposition (Neme ry, cremetory or other		Date		City or Town, St	
altimore,	Page nent ant: If ury or		Burial 2 Cremetic	(Specify)	from State		ll Cemete	ry		Baltimo		
Bal	permit. Pag Department important: I any injury once.		21. Signature of Funeral Servi	ce Licansee	Pi	7	22. Name and 2501 Gw	Address of Facility North	Nutter Fu	neral Ho	omes, Inc.	c. 216
			23a Part Enter the disease	or complications	Ihat caused the	death. Do						oximate rai Between
	Physician		The state of the s				D	. 1			Onse	t and Death
7	/Medical Examiner		Immediate Causa (Final disease or condition resulting in death)	a C)	non	C	Kenal	Fa	ilure		46	3915
		<u>_</u>	rosuling in deatiny		1 Due	a to (or as a	consequenca of):	•				
1	uted J ansit	min		b	MYP	er +	ensic	37			40	2918
ó	icete be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceusa (Disaase or Injury		Pue	a to (or as a	consequance of):					
68760,	ste be nysicie	Medicai	Ceusa (Disaase or Injury thet initiated evants resulting in deeth) Lest	C	to (or es e d							
	E 00										i	
Box	death ce attendir d for use	Physician/	Part II. Other significant cond	litions contribution	to death but no	ot reculting in	the underlying cau	en civen in Part I	23h Did	tobacco use co	ntribute to the o	num of doath?
P.0	that the de led by the a deteched to	hys	Day to		Jo death but h	pt resulting ii	· ilia unuenying cau	se given in Pan I.		Yes 2 No	3 Probably	4 Unknown
	signed by	by F	respi	197014		2114	16		-			7
Records,	w requires been si	Completed	J						24a. Was	en eutopsy ormed?	24b. Were aut avellable completio of deeth?	prior to on of cause
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ita		Be C	25. Was case rafarred to medi axaminer?	ical				26. Place of D	Daath (Chack only			
> >	0 0	2	1 Yas 2 No		1 Inpatient	2 ER/Ou	*		g Home 5□ Res	Idenca 8 Oth	er (Specify)	
Division of Vital	ding Ph h. After th funeral	<u></u>	27. Manner of Daath 1 Natural 5 □ Pen		Date of Injury (Month, Dey Ye	28b. 1		. Injury et Work?	28d. Dascribe	how Injury occur	red	
isio	Attending ir death. actor: After by the fune	cat	3 ☐ Suicide 6 ☐ Cou	stigation	Diago of Injury	At home fo	M almost footons of	1 Yas 2 No	20f Location	Street and Numb	ar or Pural Pout	Alumbar
Ď	or A effer Direc	Certification:	4 ☐ Homicide date	ermined 288.	building, atc. (S	Specify)	rm, street, fectory, o	omce		wn, State)	er or nural noute	rvumber,
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 11 Certification (Check only one)	al Examinar: On t	he basis of exa	amination en	, deeth occurred at d/or investigation, in	the time, date and ple my opinion, death oc	ca, and due to the courred at the time,	cause(s) and me date and place.	enner es stated. and due to tha ca	iusa(s)
	ithin the on the on the on the	₩ W	29b. Signeture end title of certi	ang	manner stated			icense number	-		d (Month, Day, Y	
	5 v t o		> Amatur	1 M M	lacer) N	1 0		03			
	1		30. Name end eddress of person				Type, Print)	D 1559 Jin stree	+ Pal	timone	MD	(2
	Sta	te	31. Date filed (Month, Day, Yel	er)	32. Registrans	Signature,	Dalf!	11/10/10	, , , ,		2/2	naghari Tangan
	Registr	ar	APR 0	1 1998	dung	o hundage	مسال المالية					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month Day **Physician** 1255/1 James Brooks Mary 30 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 67 Southern maryland Hospital Clinton 5. Social Security Number Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) **Funeral** 1 1 M 2 □ F Yrs **Director** 88 MD. 217-07-2617 Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Peges 1 end 2 should be filed within 72 hours efter death with the Merylan nent of Health end Mentel Hygiene. and to theme 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Madical Examines must be notified as Y□ Yes 2□ No Director P.G. Upper Marlboro 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 11729 Cheltenham RD. 20772 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Baltimore, Maryland 21215-0020 1 ☐ Yes 2 € No þ Specify. 3√2 Widowed 4 □ Divorced Black Yeer or Dates Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Saw Mill Worker Private 6 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Ernest Brooks Carrie Simms 2 19a. informent's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Mary Brooks 3407 25th St. S.E. Wash.D.C. 20020 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete Parial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or Resurrection Cemetery4/6/98 Clinton, Md. 21. Signeture of Funerel Service Licansee 22. Name end Address of Fecility Hodges and Edwards 3910 Silver Hill RD.Suitland, Md. 20746 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximeta intarvai Batween Onset and Deeth Physician Immediete Ceuse (Finel diseese or condition resulting in death) 20 da /Medical **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner Ular sician and burial-transit The law requires that the death certificate be axecuted Sequentially ilst conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Disaase or injury that initieted evants resulting in deeth) Lest Dua to (or es e consaguance of) P.O. Box 68760. physician s the buria Due to (or es e consequence of) 88 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Prostate 1 Yes 2 76 authral Sten 3 Probably 4 Unknown should be det Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed Malnuti tion page 2 2016 1 Yes 1 Yes 2 No Division of Vital **(Rending Physician:** funeral director. 25. Wes case rafarrad to medical exeminer? Be 28. Place of Deeth (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 DNaturel 5 Pending investigation 1 TYes 2 No 2 Accident rector: illed in by the 6 Could not be dataminad 3 Suicide 28e. Plece of injury - At home, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Hospital or 24 bours eige 4 Homicide 1 Certifying Physician: To the bast of my knowledge, daeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medicat Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, deta end plece, and due to the cause(s) end menner stated. 29e. Cartifian Medicai 29b. Signature and tally of certifier 29c. License number 29d. Date signed (Month, Day, Year) cer s of person who complated cause of deeth (Item 23e) (Type, Print) 9/31 Piscatawae V nop Winten 32. Registrar's Signature State sa Nevidoon Handell Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** BURRELI March 26, 1998 ELIZABETA 1:45 Am · /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) **Examiner** restman Baltimore Pr Street 2 If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. jest birthdey) **Funeral** Deys 1 M 2 NF 84 5734 Yrs. 217-14-5734 Usuel Residence of Decedent Director 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at 1 Yes 2 No NA Baltimore Directo Ma 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 506 U. S.A 21216 Funerai permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Important: If Itam 27 Is marked other than "natural", or Itama 23. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bieck, White, etc. 11. Meritel Stetus 1 ☐ Never Married 2 ☐ Married 1□ Yes 2D No 3altimore, Maryland 21215-0020 Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Wat Elementery/Secondary (0-12) Coilege (1-4or 5+) Worker NA grade 17. Fether's Neme (First, Middle, Last) 18, Mother's Neme (First, Middle, Meiden Sumame) 8 Alston To 19b. Malling Address_(Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Baltimore, ud 3022 Saunders - Daughter sstman 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from Stete any injury or Temorial Port 3-30-98 21. Signature of Funerel Service Licensee 21215 4300 Avenue Walash Balto, Ma 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel disease or condition resulting in deeth) weeks Examiner Due to (or es e consequence of): Examiner attending physician and for use as the bunal-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert ii, Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings eveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? paga 2 has 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) SISTERS Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 20 No 2 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA HOUSE After this 28a. Dete of injury (Month, Dey Yeer) funeral 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 2 ☐ Accident s eftar death. 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as sfeled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29e. Certifier

State Registrar

31. Dete filed (Month, Dey, Year) 01

30. Name and address of parson who completed cause of death (item 23a) (Type,

(Check only one)

6

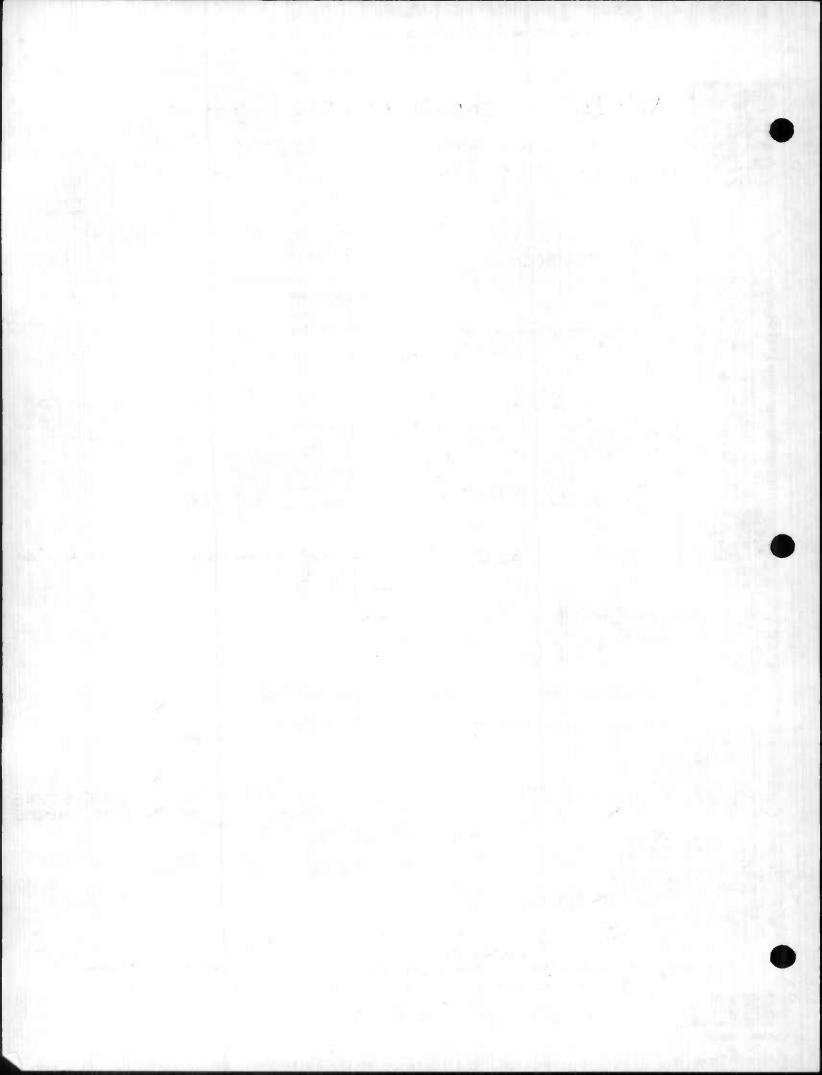
29b. Signeture and hitle of certifier



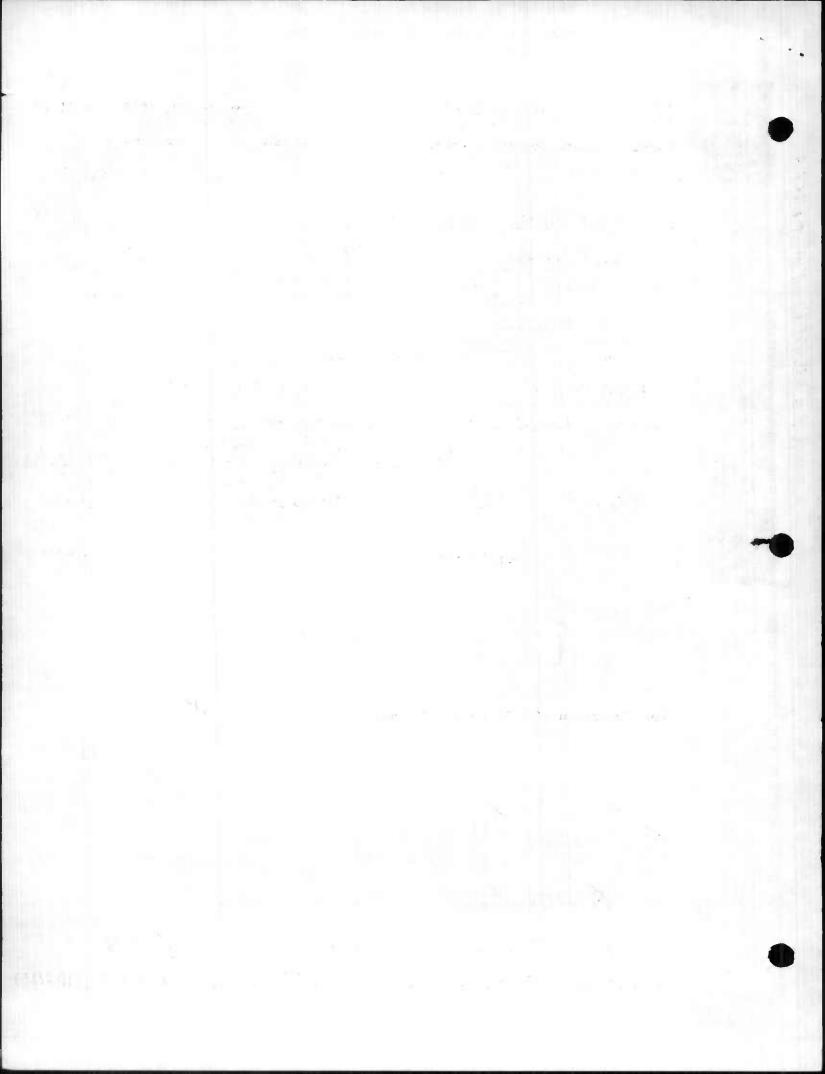
29c. License number

29d. Date signed (Month, Day, Year)

SHELTON AMBEL

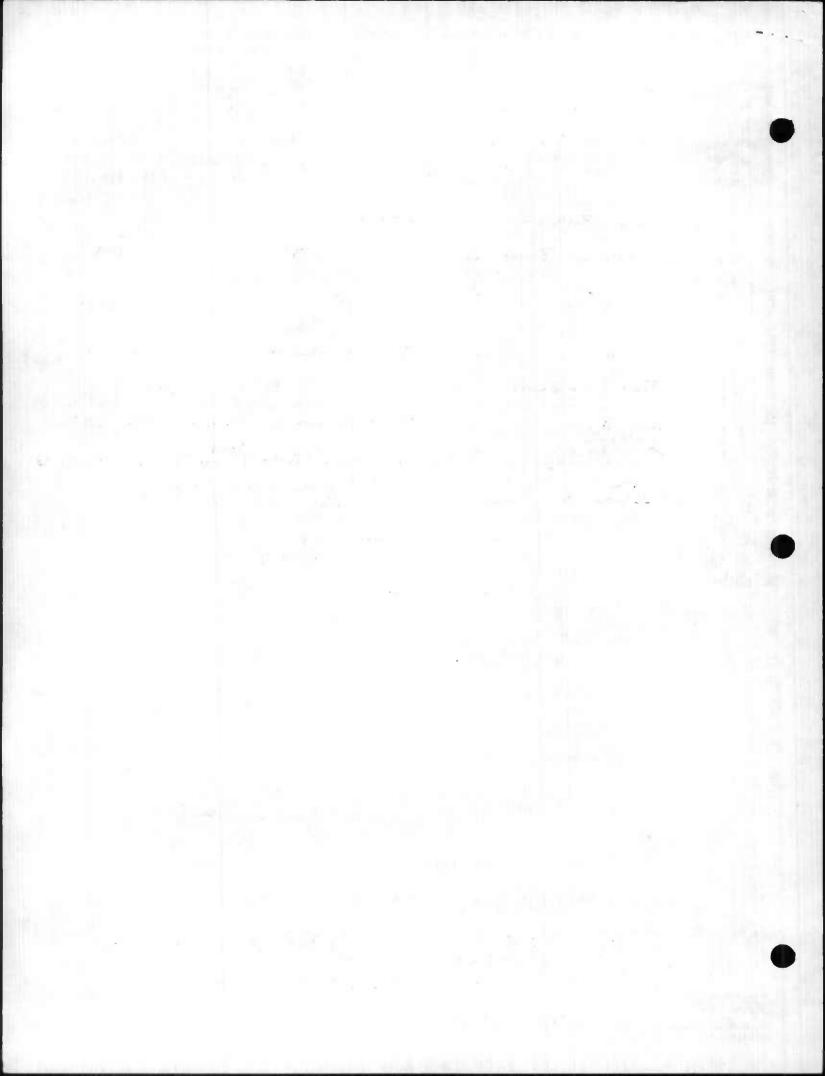


	Please T	ype or Print in B State of Maryland	d / Departme	nt of Health and	-		ble.
			Certifica	ite of Death		Reg. No.	10244
	1. Decedent's Neme (First, Middle, Last)	Λ Ι			2. Date of Do	eath Dey	3. Time of Death
Physician /Medical	Patricia Lean	BROSEKER			March	29, 199	
Examiner	4a Facility Name (If not institution, give s	street end number)		4b. City, Town, or	Location of Dear	th 4c. County	of Death
	Franklin Square Ho	ospital Center		Rosedale		Baltin	nore
Funeral	5. Social Security Number 6. Sex		ast birthday) If Und	er 1 Year If Under 24 Hrs s Days Hours Min		rth ay, Year)	9. Birthplace (State or Foreign
Director	216-28-2177	(0	(Yrs.		Julya	28 1431	Maryland
) pue	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
S. Sanyle	1 1 1 1 1 1 1	000	phills				1 ☐ Yes 2 X No
or 28=1 show anyler or 28=1 show	10e. Street and Number	ORI I FOU	RKVIIL	Lip Code		10g. Citizen of V	
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	11, Marital Status 1 Never Married 2 Married	Armed Forces?	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	to Ricen, etc.)	Blac	k, White, etc.
		1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes	208 No Specify:		Specify	White
21215-0020 4 within 72 hours effergiene transferdral Exemple to the Completed by Fu	15. Decedent's Educ	cetion	16a. Decedent's Us	sual Occupation		16b. Kind of Bu	usiness/Industry
2 K E K 121215-0 led within 72 ho lygiene. Treturi nt, the Medical Completed	(Specify only highest grede Elementary/Secondery (0-12)		(Give kind of v life. DO NOT	vork done during most of wo use retired)	orking	1	
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SE KER, and 21215-002 be flied within 72 hours. that Hygiens', condorthan 'natural', covert, the Moderal Exa	17. Father's Name (First, Middle, Last)	1		18. Mother's Na	me (First, Middle	, Meiden Sumem	(e)
Viar Viar Mente Mente of Mente	William Arnold	1		Replec	ca Mi	QUER	
Maryjand Maryjand d 2 should be file the marked or by traumatic event. To Be C	19a. Informant's Name/Reletionship (Typ	pe, Print)	19b. Melling Addre	ss (Street end Number or R	urel Route Numb	per, City or Town,	State, Zip Code)
CHNL	GORDON H. BRO	seker JR.	2509 B	URRIDGE Rd.	Balt	MORD 1	Md 21234
Baitimore, leading the search of the search	20a. Method of Disposition 1 Burial 2 Cremation 3 Re	0.0	ace of Disposition (Nametery, cremetory of	eme of other plece)	ADRIL 2	20c. Location	City or Town, State
Baitimor permit. Peges Department of I Important: If Iu any Injury or o	4 Donation 5 Other (Specify)	GRO	conmount	Cemetery	1998	Baltin	10RD Makuland
Bait permit. Depart Importa any Inje	21. Signature of Funeral Service License	00	22. Name	and Address of Facility	VCINIS F	TIMORAL	Charol
Ba permananananananananananananananananananan	KOIPYA.	P. Ladollo	2800	Hadred 1	21 An	Manago	UN 21234
THE REAL PROPERTY.	23a. Part1. Enter the disease, or complice shock, or heart feilure. List only on-	cations that caused the death	. Do not enter the m	ode of dylng, such es cardie	c or respiretory	errest,	Approximete Intervel Between
Physician	SHOCK, OF Healt Fellule. List Only Off	a causa on each mie.					Onset and Death
/Medical	Immediate Cause (Finel disease or condition	Lung Cancer					3 Months
Examiner	resulting in death)		es a consequence o	f):			
), executed n and ial-fransit Examiner							
executed an and riel-transit	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence o	f):			
0 - 6 -	ceuse. Enter Underlying Cause (Disease or Injury						
vision of Vital Records, P.O. Box 6876(Attending Physician: The lew requires that the death certificate be ar deeth. by the funeral director, page 2 should be deteched for use as the buildication: To Be Completed by Physician/Medical	that initiated events resulting in death) Last	Due to (or	as a consequence of);			
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Division of Vital Records, P.O. Box after death cent after death. The lew requires that the death cent after death. Director: After this centificate has been signed by the attending in by the funeral director, page 2 should be deteched for use ertification: To Be Completed by Physician/Mertification: To Be Completed by Physician/Mertification:							
O. o de de the street the street ysic	Part II. Other significant conditions cont	tributing to death but not resu	Iting in the underlying	ceuse given in Part I.	23b. Did	tobacco use co	ntribute to the cause of death?
P.O. het the de by the deteched	Chronic Obstructi	ve Pulmonary	Disease		1/2	Yes 2□No	3 Probably 4 Unknown
ds, F ries the signed d be def					040 11/0		24b. Were autopsy findings
cord v require been si should					perl	s en eutopsy ormed?	availeble prior to completion of cause
Rec e lew hes b ge 2 s						1.00	of death?
The cate					1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
Vitai Re lictar: The lictar: The lictaricate he rector, page	25. Was cese referred to medical examiner?	ospital:		26. Plece of De	eth (Check only	one)	
on of \ding Physic th. After this confunction of the confunction of th	1 Yes 22 No '" 27. Manner of Death	Inpatient 2 L	ER/Outpetient 3 0	DOA 4 LI Nursing	_	how injury occur	
Ing I After funer funer	t Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe	now injury occur	100
ISIC Hend deent too: the	2 Accident investigation 3 Sulcide 6 Could not be	20 a Blace of Injury. At ho			28f Location	(Street and Numb	per or Rural Route Number,
Division of the of Attending P is after death. al Director: After the funeraled in by the funeraled certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	sry, onice	City or To	wn, Stete)	
pltal filled	29a. Certifier 12 Certifying Physi	icien: To the hest of my know	uladae death occurre	d at the time, date and place	e and due to the	cause(s) and me	enner as stated
Division To the Hospital or Attendinwithin 24 hours after deeth. To the Funeral Director: Att completely filled in by the fur. Medical Certification	(Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	ion and/or investigation	on, in my opinion, death occ	urred et the time	date end plece,	and due to the cause(s)
ithin the or the	29b. Signature and title of certifier	and mainer stated.		9c. License number			d (Month, Day, Year)
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1	20 Namaced of the	ca my		00051356		721/	18
7	30. Name and address of person who cor	mpieted ceuse of death (Item	23a) (Type, Print)	100 FRANKI	LIN CA	DEB	ALTO, 1021237
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signat	ure	C - 1 -// - 1-	-11- 24	V 2. 17	11-1-11/14/14/1
Registrar	APR 0 1 1998	32. Registrar's Signat	son-Mandall				



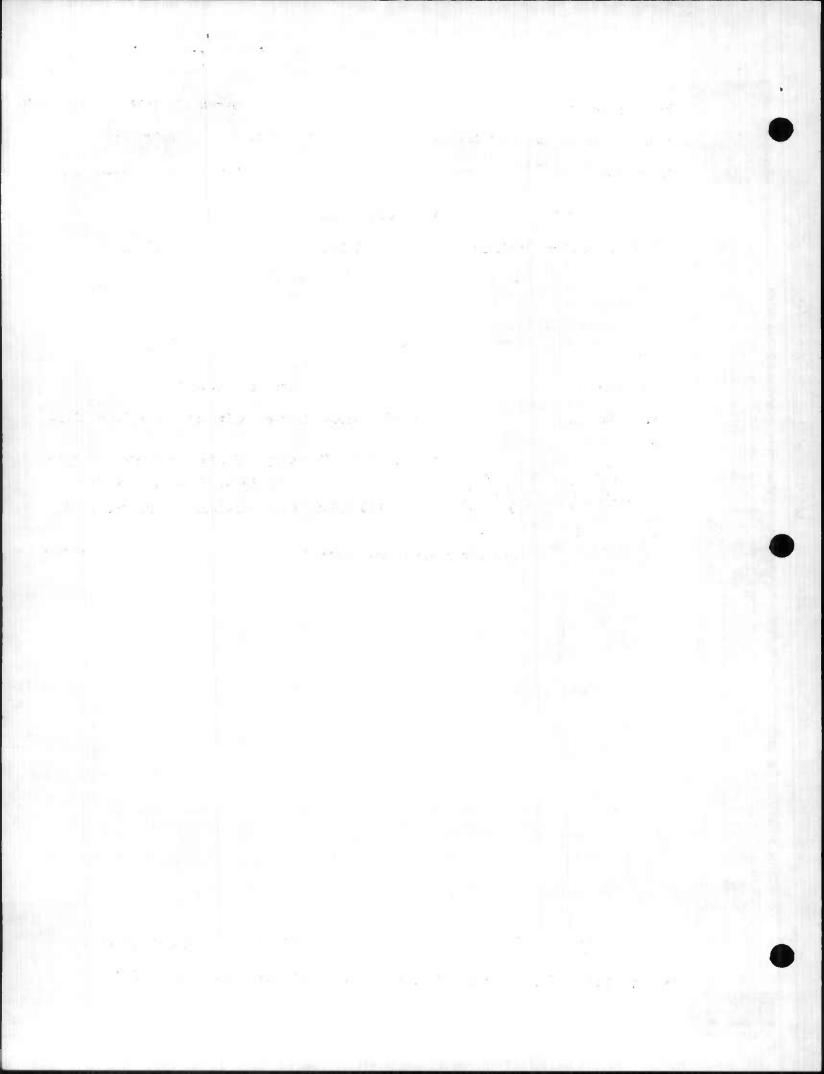
State of Maryland / Department of Health and Mental Hygiene 8 10245

			Certifica			Reg. No.						
	1. Decedent's Name (First, Middle, Las				2. Date of Dea	ath	Year	3. Time of Deat				
Physician /Medical	Mary Patricia	Barnold			March		198	1:20 0				
Examiner	4a Facility Neme (If not institution, give	e street end number)		4b. City, Town, o	or Location of Death	4c. County o	f Death					
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Funeral Pirector	217 20 1911	Sex 7. Age (In y	L8 Yrs.	der 1 Year If Under 24 Hi hs Deys Hours Mi	n. (Month, Da)	V, Year)	9. Birthplac Country	e (Stete or For				
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23a or 2 unit be n rai Dire	100. Street and Number 25 Battersea T	Bridge Ct.	10f.	Zip Code 21093		10g. Citizen of Wi	g. Citizen of What Country?					
Coppurers or results and wenter trypers. Important: If them 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified at page. To Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		cedent of Hispenic Orlgin? specify Cuban, Mexican, Pures 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Rece Black Specify:	- American , White, etc White					
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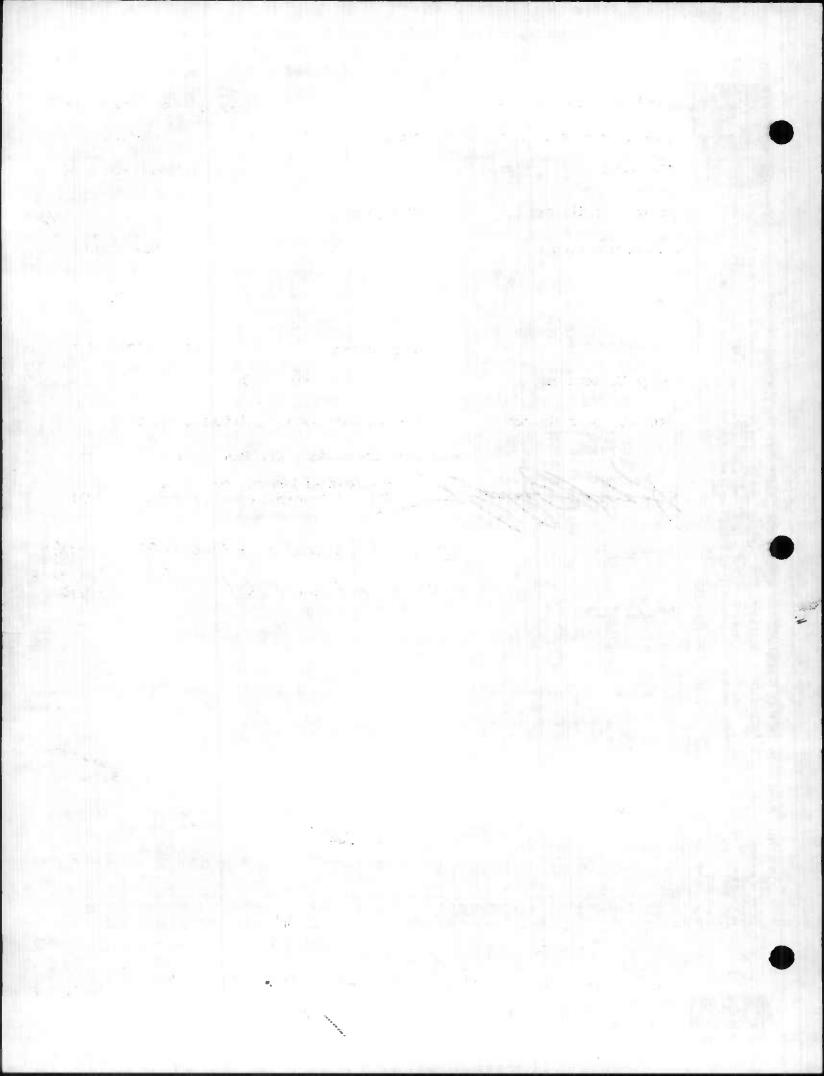
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Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental debyte than "retural", or items 23s or 28s-f show mortifactured in the Medical Exercities must be notified at optice.	by Funer	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Agned Forces? 1 Yes 2 No If Yes, Give Year or Dates:	orces? If Yes, specify C 2 □ No ve 1 □ Yes 2 ☑			lispenic Origin? (S an, Mexican, Puer Specify:	14. Rac Bled Specify	e - Americ ck, White, White,	etc.		
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Baltimore,	Page ent o nt: If I		1 Burial 2 Cremetion 3 C 4 Donation 5 Other (Specif	JRemoval from State				emetery	3/31/98	Baltime	ore.	Marv1	Land
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Ö	Depa Impo any ir		Jalan (10	216.01	2				ippel Fu			.nc.	
	Physician		23a. Part / Enter the disease for com shoot, or heart failure. Vist only	Trest, Maryland 21200 Maryland Interval Between Onset and Deat									
)	/Medical		Immediate Cause (Final	Verentet		hagaa1	aana	or			į	1 mon	th
	Examiner		disease or condition resulting in death)		e Metastatic esophageal cancer 1 month Due to (or es e consequence of):								
-	p #	ner			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,							
	tificate be axecuted g physician end es the buriel-transit	edicai Examiner	Sequentially list conditions,	Due Due	Due to (or as a consequence of):								
60,	cian cian buriel	ai E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	C									
68760,	phys s the	dlc	resulting in deeth) Last			į							
	ding se es												
Вох	death cer e attendin ed for use	ciar	Death Other desident and distance	ant conditions contributing to death but not resulting in the underlying cause given in Part I.							mtellusta t	o the caus	e of death?
o .	the the	Physician/N	Pert II. Other significant conditions of	ontributing to death but no	ot resulting in	sulting in the underlying cause		en in Part I.	23b. Did tobacco use con				Unknowr
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Re	The law ata hes t page 2 s	Omp							10	Yes 2 No		☐Yes 2	□No
	delan: The certificata rector, pag	Bec	25. Was case referred to medical					26. Place of De	ath (Check only	one)			
of Vital	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ᠌ No	Hospitel:	2 ER/Out	patient 3	DOA Oth	or:	Home 5 Resi		ner (Specil	fy)	
o uo	iding Physith. Ith.: After this a funeral d		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigatio	28a. Date of Injury (Month, Dey Ye	28b. Ti		28c. Injur	y at k? Yes 2 □ No	28d. Describe	how injury occur	red		
Division	after des Director J in by th	Certification:	3 Suicide 6 Could not be determined			m, street, fact	ory, office		28f, Location (City or To	Street end Numb wn, Stete)	ber or Run	al Route N	mber,
	To the Hospital or Attending Physician: within 24 hours after death and To the Funeral Director. After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Cartifying Pt (Check only one)	ysician: To the best of my niner: On the basis of exa and manner stated.	mination and	death occurre /or investigate	ed at the tir on, in my o	me, date and place plnion, death occ	e, and due to the urred at the time,	cause(s) and madate and place,	anner as a and due t	stated. to the cause	e(s)
	ithin o the omple	Me	29b. Signature and title of certifier	and mainer stated.		2	29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year,)
	F ≥ F ŏ		Mv -	MI			71	848 7		March 2	27,19	98	
,	(V)		30. Name and address of person who	completed cause of deeth	(Item 23a) (T	Type, Print)							
(211		Dr. Myo Thant, 6	830 Hospital	Dr.,	Suite	206,	Baltimor	ce, Mary	land 212	237		
	Sta		31. Date filed (Month, Dey, Year)	1998 32. Registu	Signature Days	an-Rand	all						
	Registr	ar	MLK O T	1000			-						



State of Maryland / Department of Health and Mental Hygiene 8 10247

					Cer	tificate	e of	Death			Reg. No.			
Physiciar /Medica	n	1. Decedent's Neme (First, Middle, La Dorothy Ameli		k						2. Date of Dec Month March	29 ·	Yeer 1998	3. Time of Deeth 2:30 AM	
Examine		4e Fecility Name (If not institution, giv Manor Care Nursir	e street end num	r / Ros	sville	2	•	tb. City, Too Ross		cation of Deeth		of Death	re	
Funeral Director		5. Sociel Security Number 217–20–8116	Sex I□M 2⊠XF	7. Age (In yrs. k 91	est birthday) Yrs.	If Under Months	1 Yeer Deys	If Under : Hours		8. Dete of Birt (Month, De Aug. 31	, 1906	9. Birthp Coun Mary	lece (Stete or Foreign (NX) 71and	
Meryland f show		Usuel Residence of Decedent 10e. State Maryland Baltimo	ore		, Town or Lo Nottir							1	0d. Inside City Limits 1 ☐ Yes 2 No	
with the 3a or 28a	Direct	10e. Street end Number 4802 Royahn Avenu	ie		1	10f. Zip 212					10g. Citizen of Whet Country? U.S.A.			
Maryland 21215-0020 42 should be filed within 72 hours after death with the Meryland th end Mental Hygiene. 7 is marked other than "natural", or items 23a or 28s-f show traumetic avent, the lead call Examinar must be notified as	by rur	11. Maritel Stetus 1 □ Never Married 2 □ Merried 3 ☑ Widowed 4 □ Divorced	12. Wes Dece Armed For 1 Yes If Yes, Give Year or Da	2 Ճ No 9	U,S. 13. Wes Decedent of If Yes, specify Cub		ify Cubi	Hispenic Orlgin? (Specify Yes or Noben, Mexican, Puerto Rican, etc.) Specify:			No- 14. Race - Ar Bleck, W Specify: W		etc.	
21215-0020 d within 72 hours af giener in then "natural", or the Medical Event	Completed	15. Decedent's E (Specify only highest on Elementery/Secondery (0-12)	ducation ade completed) College (1	-4or 5+)	16e. Deced (Give life. I			etlon during most d)	t of worki	ng L	16b. Kind of B			
Maryland 212 d 2 should be filed with th end Mental Hygiene. 7 is marked other than traumatic avent, than	o Re	17. Fether's Neme (First, Middle, Last George H. Watchma						18. Mothe Mary			Maiden Sumer	ne)		
C = 0 -		19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State 4802 Royahn Avenue Baltimore, Md. 212										Code)		
Ses H		20e. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specia		CE	lece of Dispo emetery, crem cimore	netory or o	ther ple	ce) / 4	1/1/1	998	20c. Location Baltime			
Baltim permit Pa Departmen Important: any injury	-	21. Signature of Funetal Service Los	7200	61						1 Home	P.A. Essex, M	1d 21	1221	
x 6876(entificete be ling physicie e as the bu	Med	23 Part 1 Enter the disease, or construction of the second shock, or heart tailure. List of the second shock of the second sho	e b c	Due to (or		PUC juence of):	mo	NAR	Y	EMBE	ou sm		interval Between Onset end Death 5 DAYS more (Train YR	
P.O. Bot at the death of by the atter	Physician	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute 1 Yss 2 No 3 Pert II.										the cause of death?		
0 8 8 B	2									24a. Wes	en eutopsy ormed?	ev	ere autopsy findings eilable prior to mpletion of cause	
f Vital Rec ysicien: The lew is certificate hes b director, page 2 s	e completed	25. Wes case referred to medical						26. Plece	of Deeth	1 Check only			déeth? ☐ Yes 2☐ No	
	0	examiner? 1 ☐ Yes 21 No	Hospitel:	patient 2 1	ER/Outpetier	it 3□ DC	A Off	ar			dence 6 Ot	her (Specif	y)	
0 4 5 8		27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigatio	28e. Dete o (Monti		28b. Time of Injury		8c. Injui Wo				how Injury occu			
Division of the funding P rate after death. I blue for after the funding P rate funding posterior and the funder funding posterior after the f	Sullic	3 Suicide 6 Could not be determined	286. Piece	of Injury - At ho	me, ferm, str	eet, fectory	, office			28f. Location (City or To	Street end Num vn, Stete)	ber or Rura	Il Route Number,	
Division of to the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of Madical Cartification. To		29a. Certifier (Check only one) The Certifying Property one)	nysician: To the niner: On the ba end menn	sis of exeminet	vledge, death lon end/or in	occurred restigetion,	at the tir	me, date en opinion, dee	d plece, o	end due to the ed et the time,	cause(s) and m date end plece,	enner as s and due to	tated. the cause(s)	
To the To the Complex	-	29b. Signeture end title of certifier	4				XZ	e number C 6 4	1		30 h	10 vc	1. 1998	
6		30. Name and address of person who RMTH SR	completed ceuse		23e) (Type,	Print)	ne t	CRIV	or 1	veck o	Road	Ball	une mo	
State Registra		31. Dete filed (Month, Day, Year) APR 0 1 1998	32 Re	agistrer's Signet	. Mandall								4/22/	

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item#20b per FH G758 4/10/98 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yeer78 Month **Physician** Collison 7:35 March twenty eight homas /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner medical Center CITY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** ₩ M 2□ F 75 217-12-3320 Yrs. Director MAY 27,1922 MARYLAND Usuel Residence of Decedent death with the Meryland 10a State 10h Counts 10c. City. Town or Location 10d. inside City Limits "natural", or items 23s or 28s-f show MD CITY BALTIMORE CITY 1 XYes 2 No Director 10e. Street end Number 10f. ZIp Code 10g, Citizen of What Country? U.S.A. 21224 3317 HUDSON STREET Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: 14. Rece - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bieck, White, etc. filed within 72 hours efter Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) MAINTENANCE GOOD WILL 5 7 is marked other traumatic event, it 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be fament of Heelth and Mental Int: If item 27 is marked of JENNIE PEADE THOMAS COLLISON, SR. 19e. Informent's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SUSAN CORASANITI 917 E. SEMINARY AVENUE BALTIMORE, MD21286 important: If item 27 any injury or other 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) GREEN MOUNT CEMETERY Department 3/30 BALTIMORE, MD Oaklawn Cemetery 22. Name and Address of Facility 21. Signatur@of Funeral Service Licensee CHARLES S. ZEILER & SON, INC. 234. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, euch es cardlec or respiratory errest,

Approximate Approximete Interval Between Onset end Deeth **Physician** /Medicai Immediete Ceuse (Finei heum onia disease or condition resulting in deeth) Examiner Physician/Medical Examiner burial-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In death) Last Due to (or es e consequence ot): physician s the burial P.O. Box 68760. Due to (or es e consequence of): 98 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown Cardio Vescular Discase Records, 24b. Were eutopsy tindings evelteble prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? 1 Yes 2 K No 1 ☐ Yes 2 No certificate of Vital Libertital of Attending Physician:
24 hours after death.
Funeral Director: After this certifice etely filled in by the funeral director, t Be 25. Wes case reterred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation Neture 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted. Medicai 29a. Certifier (Check only one) 29b. Signeture and titlerot certifier 29c. License number 29d. Dete signed (Month, Dey, Year) MO

Bayvier

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

APR 01 1998

Howell

32. Registrer's Signature

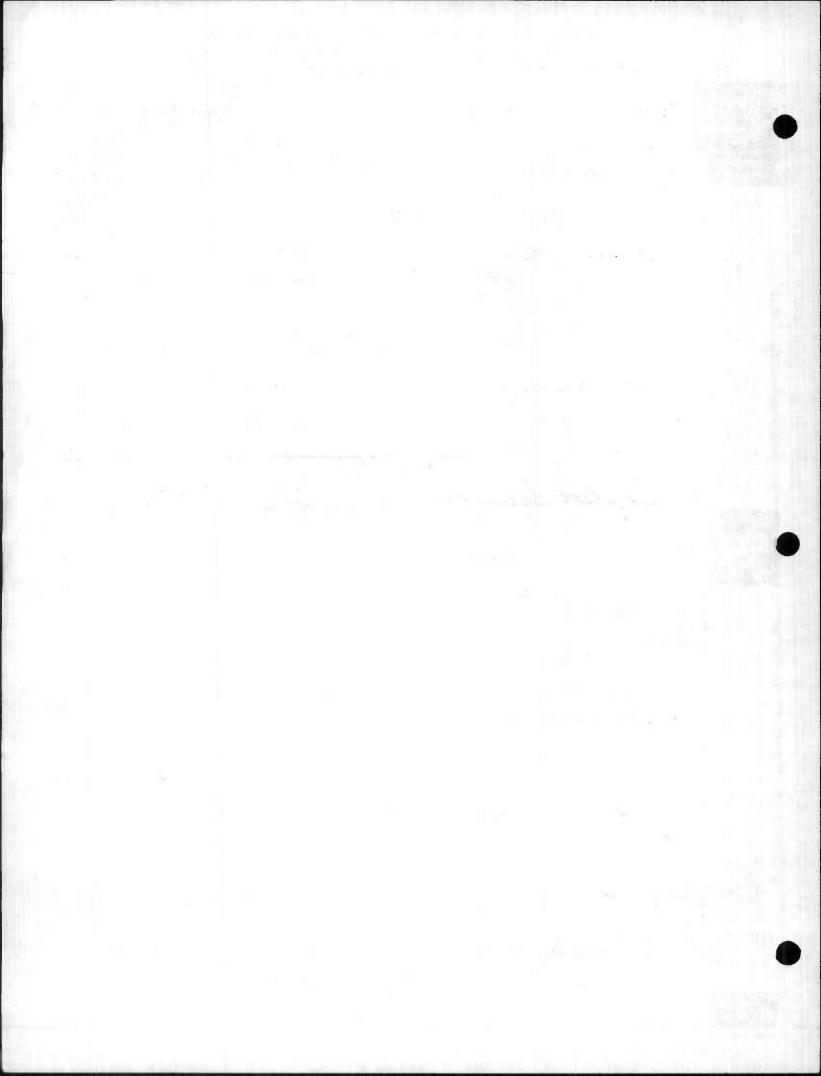
Julia Davidson

DHMH 16 Rev 6/95

State

Registrar

Eric E 31. Dete filed (Month, Dey, Yeer)



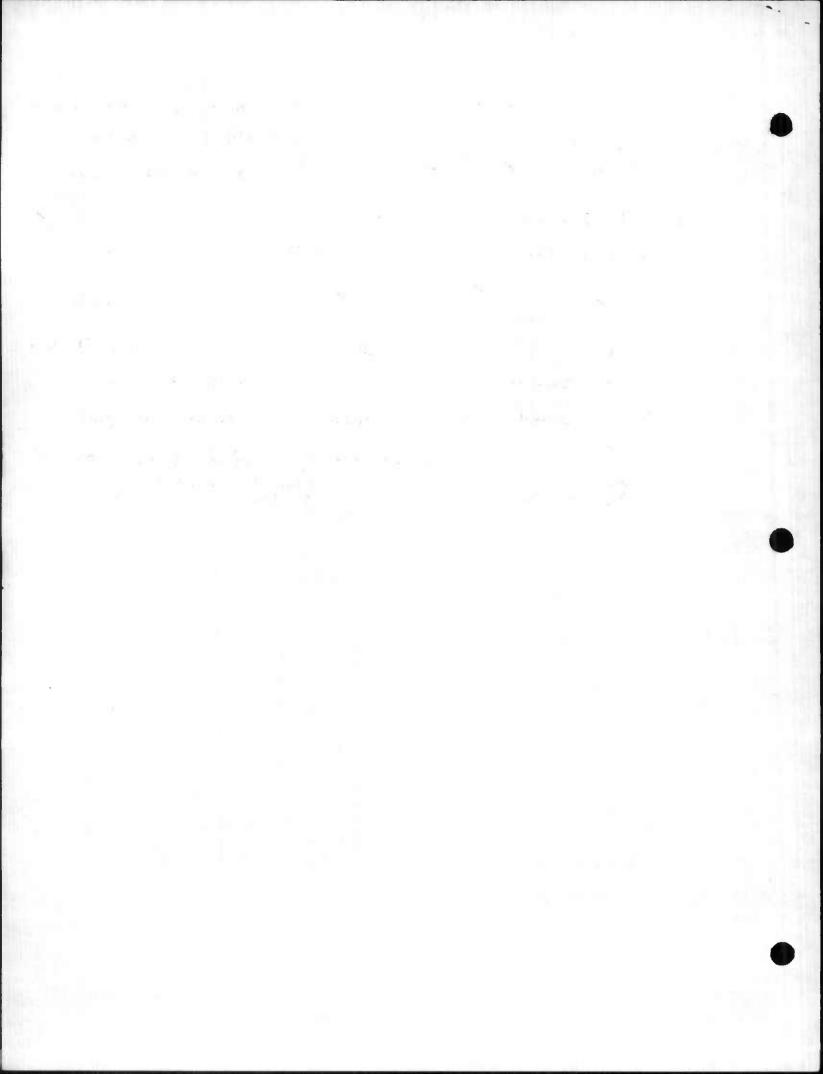
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month DelphiA 12:20 AM March /Medicai 4a. Fscility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville Inc. sosliva MANGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) August 14 1909 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F Months Days Hours 88 8971 Yrs. Director Arkansas Usual Residence of Decedent the Maryland 10a State 10b County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Maryland TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA PIACE Lombardy death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yas, Giva Year or Dates: 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 ☐ Widowed 4 Z Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry al Hygiene. Elamentary/Sacondary (0-12) Coilege (1-4or 5+) State of Maryland Clerk 12 permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If frem 27 is merked other any Injury or other traumatic events. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Isabelle DAVIDSON Charles Fullington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sen Maplehurst Frederick Clement Monkton 21111 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State MArch 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Baltmore. 27 1998 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Chapel EVAMS 2325 Timonium 21093 York Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediata Cause (Final CANCER disease or condition resulting in death) WITH METASTASES Examiner Due to (or as a consequence of). Examiner attending physician and for use as the bunal-transit be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ADVANCED AGE p 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was casa raterred to medical examiner? Be 28. Place of Death (Check only ona) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 this 27. Manper of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: or Attending P ster death. 1 Natural 5 Pending Investigation MA 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours all To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner stated. edical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-30-98 D 29301 30. Name and address of person who completed ceuse of daath (Item 23a) (Type, Print) TULLY 2005 YORK RD

32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year) APR 0 1 1998



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dev **Physician** 28,498 unice ViRGINIA LOSIER MARCH 0010 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Feclity Neme (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months Day, Year) (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** Deys 1 M 280 F Yrs. AUG.9, 1903 215 30 1208 Usuel Residence of Decedent MARYLAN Director the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 28 No Directo SALISBURY Wiconico MARYLAW 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23s or traumatic event, the Mindical Examinar must be AVE S.A. 1404 20 15RS00 91801 Funerai 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: p 3K Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 7 and Mental Hygiene. filed within Elementery/Secondery (0-12) College (1-4or 5+) 0-150 HOMEMAKER AT HOME 8YRS Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be GARDAZA V. GARDNER JOHA KOY 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Health em 27 20b. Plece of Disposition (Name of cemetery, crematory or other place) SALLSBURY, MARYLAND
Dele 20c. Location - City or Town, Stele DANIEL E VSSERY Baltimore. MARCH31 20e. Method of Disposition Pages 8 Department of Important: If It 1 Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 0 BALTIMORI MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) HARK 20000 22. Name end Address of Fecility
EVAN FUNERAL CHAPIL 21. Signature of Funeral Septibe Licenses -BILAIR P.A. 21050 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart fellure. List only one cause on each line. MARYLAND Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine end I-transit certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): physician er s the buriel-t Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): 98 esn ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed I þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed page 2 1 ☐ Yes 2 ☐ No 1 Yes certificate or Attanding Physician: director, 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Be 1 ☐ Yes No 27. Menner of Deeth Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpetient 2 ER/Outpatient 3 DOA 2 funeral 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Netural Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ofter deatl 6 Could not be determined 28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Hospital Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier edicai To the Hosp within 24 ho To the Fune completely f 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 029105 Juddestor 30. Name engladdress of person who completed cause of death (Item 23e) (Type, Print) 106 milford St. Salisbury md Huddleston

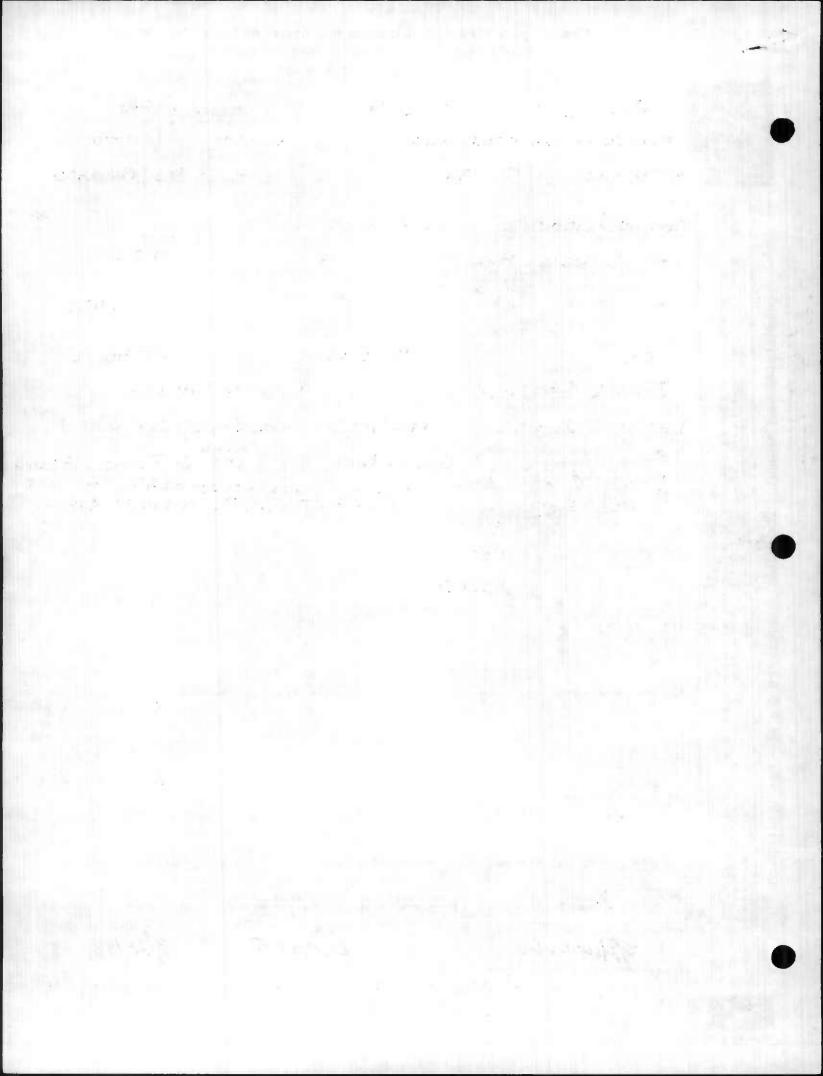
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31. Dete filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** MARCH DUGAN JoHN 0728 HM 1998 26 /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner RANDALLSTOWN NORTHWEST HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 8. Date of Birth 9. Birthplece (State of April 10, 1914 Maryland 5. Sociel Security Number 9. Birthplece (Stata or Foreign **Funeral** 1 ☑ M 2 ☐ F Days Hours 216-07-3065 Director Usuel Residence of Deceden the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Director 1 ☐ Yes 2K No Maryland Carroll Sykesville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 7200 3rd Avenue 21784 items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - Amarican Indien, Bleck, White, etc. 11 Marital Status 13. Wes Dacedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Ricen, atc.) permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hygiene. Important: If item 27 is merked other than "natural", or her any injury or other treument. 1 XYes 2 No If Yes, Give Year or Detes: 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade com 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) College (1-4or 5+) Engineer Steel 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Ferdinand Dugan Melanie Boone 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosemary Dugan/wife 7200 3rd Avenue, Sykesville, Maryland 21784 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street 21. Signature of Fun rel Service Licensee Ronald S. Wade Director Baltimore, Maryland 21201 In a Linear tha disease, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Finel · SEVERE CONGESTIVE CARDIOMYOPATHY disease or condition resulting in death) **Examiner** Examiner The law requires that the deeth certificate be executed physician end s the buriel-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in daath) Lest Due to (or es a consequance of): Box 68760, Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SEPSIS, ARDS Records, 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Be Completed 24e. Wes en eutopsy performed? certificate 1 ☐ Yes 220No Division of Vital Hospitat or Attending Physician: 24 hours efter death. Puneral Diractor: After this certifica etely filled in by the funeral director, p 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Pinpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Neturel 5 Panding 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medicel Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner stetad. 29a, Certifier 29d. Data signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number MARCH 26, 1998 30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) C. RAVI MD NHC, BALTO. MO 21133

State Registrar

31. Dete filed (Month, Day, Year) APR 0 1 1998

32 Registrar's Signeture This Davidson

A STATE OF THE STA

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

/Medical

Examiner

Director

1. Decedent's Name (First, Middle, Last)

4a Fecility Name (If not institution, give street end number)

1**⊠** M 2□ F

APR 0 1 1998 >

THEODORE

5. Social Security Number

194-26-8753

11125 LYNN DRIVE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DRIGAN

Yrs.

7. Age (In yrs. last birthday)

65

Certificate of Death

Deys

entai riygit	. No. 9	8 1	0252
2. Dete of Deeth Month	Day	Year	3. Time of Deeth

BALTIMORE COUNTY

0135AM

Birthpiace (State or Foreign Country)

1998

4c. County of Death

MARCH 29,

Nov. 26, 1932

4b. City, Town, or Location of Death

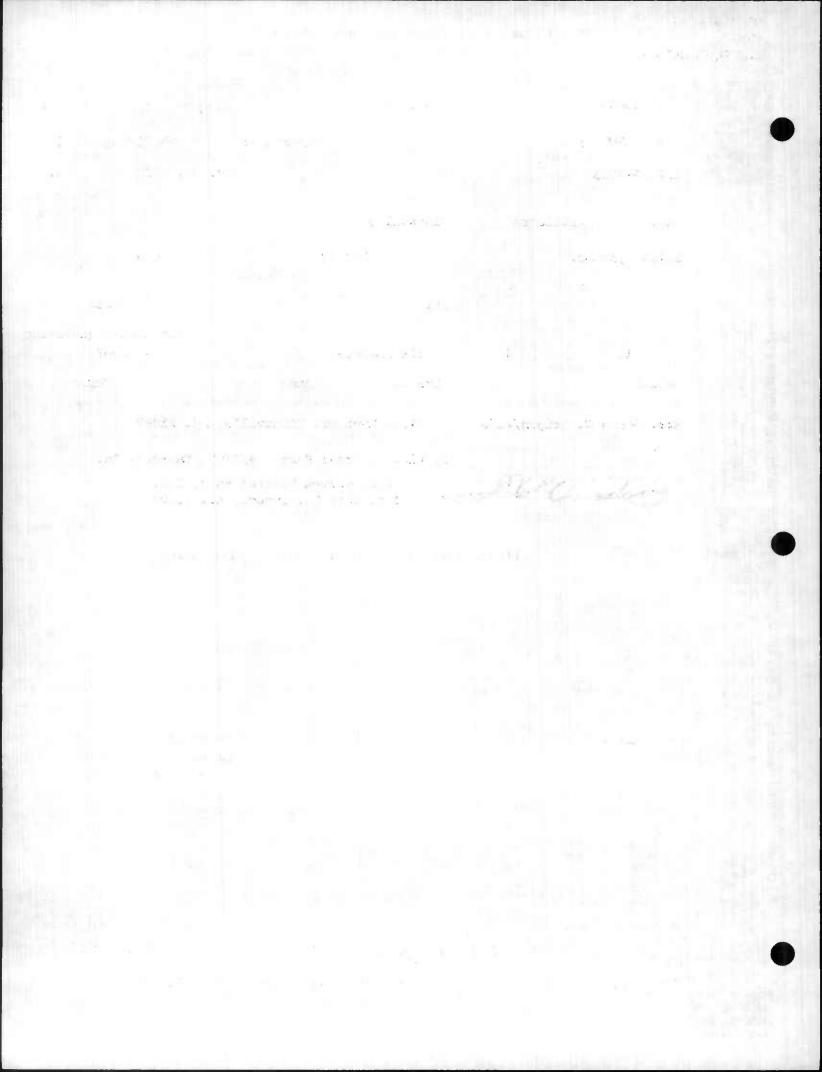
KINGSVILLE

Hours

Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 21 a marked other than "natural", or items 23e or 28e-4 show any Injury or other traumable event, its Medical Examiner man be notified at	
	Physicia /Medic Examin	֡
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be assocuted within 24 hours after death. To the Funeral Offector: After this certificate has been signed by the attending physician and completely filled in by the funarial director, page 2 should be detached for use as the burial-fransit	

Usual Residence o	f Decedent										
10a. Stete	10b. County		10c. City, Tow	m or Location	7					1	0d. inside City Limits
Md.	Balti	more	Kings	sville							1 ☐ Yes 2 ☑ No
10e. Street and Nu				10f. Zip Code 10g. Citize						net Coun	itry?
11125 Ly	nn Dr				21087				USA		
11. Maritel Status	m DI.	12. Wes Decedent		13. Wes E	Decedent of H	lispenic Origin?	(Specify Yes or N	10-	14. Rece		en Indien,
1 ☐ Never Man	ied 2 Married	Armed Forces'				an, Mexican, Pue	erto Rican, etc.)		Bleck,	, White,	etc.
3 ☐ Widowed		If Yes, Give Year or Detes:		1 Y	es 28 No	Specify:			Specify:	Whit	
	15. Decedent's Ed		1	. Decedent's	Usuel Occup	etion		16b.	Kind of Bus		
	cify only highest gra	ide completed)	-	(Give kind of life. DO N	of work done OT use retired	during most of w	orking	Th	e Mar	k En	gineering
Elementary/Second 12	ondary (0-12)	College (1-4or		Lf Emp	loved				Com	pany	,
17. Fether's Neme	(First, Middle, Last)					18. Mother's N	ame (First, Middl	e, Maide	n Sumeme)	
Danie1			Drig	gan		Anna			•	Fe	erko
19e. Informent's N	ame/Relationship (Type, Print)	19t	b. Mailing Ad	dress (Street	and Number or I	Rural Route Num	ber, City	or Town, S	tete, Zip	Code)
Mrs. Don:	na C. Dri	gan/wife	11	1125 L	ynn Dr	. Kingsv	ille, M	d. 2	1087		
20e. Method of Dis			cemete	of Disposition	(Neme of	ce)	Dete	20c. I	Location - C	ity or To	wn, Stete
	☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removel from State y)			moria1		4/2/98	Tam	agua,	Pa.	
21. Signature of Eu	maral Servica Licer	1500			ne end Addre		cal Homo	Tn	0		
500	C D	THE WAY					cal Home son, Md.				
23a. Pert1. Enter	the disease, or com	plications thet ceuse	d the deeth. Do						04	4	Approximate Interval Between
SHOCK, OF HOS	art failure. List only	one cause on each i	iirie.							-	Onset end Deeth
Immediete Cause	(Finel	1410.00		· · ·	- 2-0-5		ο Mic.			1	
resulting In deeth)		e. Athero	Due to (or es e			vastula	DISC	0126			
			200 10 101 00 0	obilacquolio	u 01).						
Sequentielly list co	anditions C	b	Due to (or es e	consequence	a of):						
if env. leeding to in	nmediete										
cause. Enter Unde Ceuse (Disease or thet initiated event	S	C	Due to (or es e	consequence	a of):					-	
resulting in deeth)	Last				,					i	
		d								-	
Pert II. Other eigni	ficant conditions of	ontributing to death i	but not resulting i	in the underly	ying cause giv	en in Part I.	23b. DI	d tobacc	o uee cont	ribute to	o the cause of death?
		•					10	Yee	2 No	3 Prof	bably 42 Unknown
							24a. Wa	s an eut	opsy	24b. W	ere eutopsy findings
							Limite	formed?		00	empletion of cause deeth?
									2574		
05 14/22 2222 22/2	and to medical							₹ Yes	ZJEJ NO	16	Xyes 2□ No
25. Was case reference exeminer?		Hospitel:			Oth	ADE:	eeth (Check onl)				
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1 Neturel 2 Accident	5 Pending investigation	28a. Dete of Inj (Month, De	By Year)	Injury	28c. Injui World 1	rk? Yes 2 □ No	200. 000010	o now m	diy occurre		
3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Plece of In	ijury - At home, fe tc. (Specify)	erm, street, fo	ectory, office		28f. Location	(Street a	and Numbe	r or Rure	al Route Number,
4 🗀 Homicide		building, e	ic. (Specify)				Olly of 1	UW/1, 316	10)		
29a. Certifier (Check only one)		yelclan: To the best niner: On the basis of end menner s	of examinetion er								
29b. Signeture end	I title of certifier	resulting the			29c. Licens	e number		29d. D	ate signed	(Month,	Dey, Year)
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Al	ysy.	m V	ner	9 110		C.M.E.		[v]/	ARCH 2	.9,	1220
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Registrar



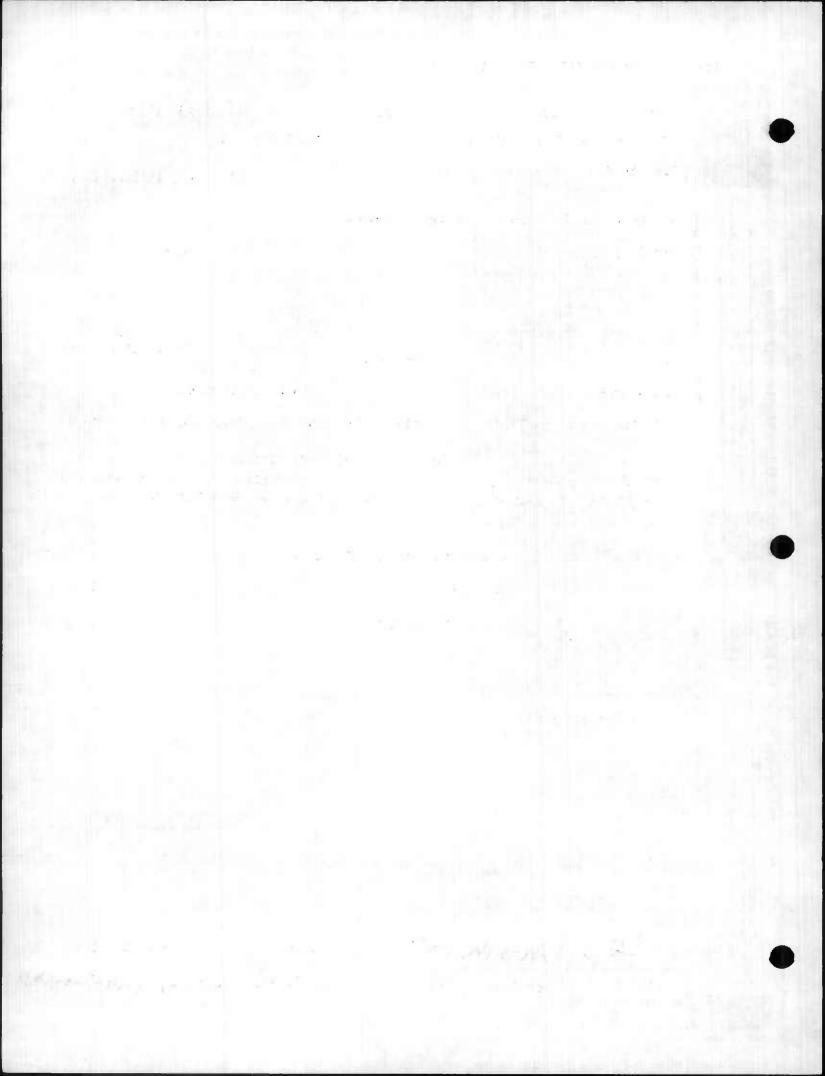
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State of Maryland / Department of Health and Mental Hygiene Q 1025

	24a per PHY Film 1. Decedent's Name (First, Middle, L		-	Cer	tificate of	Death	2. Date of Dea		3	3. Time of Death
ysician	JOHN ALL			D.A	AFT		Month MARCH 2	Day 25. 1998	Year 1	6:10
Medical 48 aminer 48	la Facility Name (If not Institution, g)	DE	AF I	4b. City, Town, or L			2	
attituet	THE JOHNS HOPKI	NS HOSPITA	L			BALTIMORE	CITY			
	5. Social Security Number 216-94-8373	Sex 7. A	ge (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		8. Dale of Birth (Month, Day			e (State or Foreign
	Jsual Residence of Decedent						SEPT. 1	3, 1930	LNGLA	NU
3 . 10	10e. State 10b. County		10c. City, To							Inside City Limits
cto	MARYLAND PRINCE	GEORGE	UPPER	MARL	BORO					1 ☐ Yes 2 📉 No
al Director	10e. Street and Number 11913 WIMBLETON	ST.			10f. Zip Code 20774			U.S.A.	What Country	7
by Fur	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 HYes, Give Year or Dates:	? No		Ves Decedeni of Yes, specify Cul	Hispanlc Orlgin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - American ck, White, etc. WHITE	
Completed	15. Decedent's (Specify only highest g	Education	16	a. Decede	ent's Usuai Occu	ipation during most of work	ina	16b. Kind of B		
1 10	Elamentary/Secondary (0-12)	Collega (1-4or	5+)	lifa. D	O NOT use retin	during most of work ed)		CIVIL S DEPT. O		
- CO	12	4		IANAG	ER	18. Mother's Nam				NOL
- B	17. Father's Name (First, Middle, Las								10)	
To Target	ALLEN GEORGE DAF		10	No. Admilia.	- Address (Chro	KATHLEEN			Ctata Tia Ca	oda)
nen .	19a. Informant's Name/Relationship MRS. BERNICE D.					TON ST. U	JPPER MA			
20	20a. Method of Disposition	DAFI-WIFE	20b. Piace	of Dispos	sition (Name of		Date	20c. Location -		
ury or o	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State cify)		PEAK		TORY, INC		BELTSVI	LLE, M	ID
any In	21. Signature of Funeral Sence Lo	Skarde				ess of Facility SIN				
2	23a. Part1 Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each I	ed the death. Do	not ente	or the mode of dy	ring, such as cardiac	or raspiratory ar	rast,	Ar	proximata tervai Between
ian									Or	nset and Death
d	Immediate Cause (Final diseasa or condition	COLOR	RECTAL C	CANCE	ER METAS	TATIC			3	YEARS
	rasulting in daath)	UROSE	Due to (or as a	a consequ	uenca of):				3	DAYS
am am	Sequentially list conditions,	b	Due to (or as a	consequ	uanca of):					
EX C	Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Diseasa or Injury	COLOF	RECTAL C	CANCE	ER				4	YEARS
m 0 1	cause (Disease of multy) that initialed events resulting in death) Last	С	Due to (or as a consequence of):							
for usa		d								
Physic	Part II. Other significant conditions	contributing to death t	but not resulting	In the un	derlying cause g	iven in Part I.	23b. Dld t	v		e cause of death? bly 4 □ Unknowi
d by PI	POLYPOSIS (COLI					"	108 ZEINO	3 Probab	ny 4 Olikilowi
200							24a. Was	an autopsy	24b. Were	autopsy findings bla prior to
Completed							peno	med?		letion of cause
omp							101	res 2 DNo		es 2 No
ō 0 2	25. Was casa referred to medical	T				26. Place of Dea				-
o B	examiner? 1 ☐ Yes 2 ZNo	Hospital: 1 1 Inpati	ient 2 ER/0	Dutpatient	3 DOA O	ther:	ome 5 Resid		ner (Specify)	
<u></u>	27. Manner of Deeth 1 \(\begin{align*} \text{Anatural} & 5 \text{Pending} \\ 2 \text{Accident} & \text{Investigati} \end{align*}	28a. Date of Inju (Month, Da		. Time of Injury	28c. Inju		28d. Dascribe h			
ed in by the funer: Certification:	3 Suicide 6 Could not determine	A 250 Placa of in	njury - At home, etc. (Specify)	farm, stre	eet, factory, office	9	28f. Location (S City or Tox		ber or Rural R	loute Number,
ical Ce	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of examination e							
Med C		and mannar s	tated.		20c Line	ase number		29d Date sions	ed (Month De	v Year)
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Medical Time		aminer: On the basis of and mannar st	of examination estated.	end/or inv	astigation, In my 29c. Licer RES		red at the tima,		and d	due to th

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Day MARCH 30, 1998 JULIA MARTIN DILLARD 6:10 A.M. 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death 1812 RUXTON AVE. (HOME) BALTIMORE If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, OCTOBER 5. Social Security Number 7. Aga (In yrs. last birthdey) 9. Birthplace (Stata or Foreign Days Hours Min 1□ M 2√1 F 14,1914 VIRGINIA Yrs. 231-09-8217 83 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RUXTON AVE. 1812 21216 USA 12. Was Decedent Evar in U,S. Armad Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - Amaricen Indian, Biack, Whita, atc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 ☐XNo Specify: Specify: AFRO. AMERICAN 3 Widowad 4 Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) DOMESTIC HOMEMAKER 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) ACK LAW MIRISON MARTIN 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) HILLARD NIECE 1812 RUXTON AVE, BALTIMORE, MARYLAND 21216 SHIRLEY 20b. Piaca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Buriai 2 Cramation 3 Ramovai from Stata CARVER MEMORIAL GARDEN 4/ /98 MARTINSVILLE, VA. 4 Donation 5 Other (Spacify) 21. Signatura of Funaral Service Licensaa LLOYD M. ESTEP ESTEP BROTHERS FUNERAL HOME, P 1300 EUTAW PLACE, BALTIMORE, 23a. Part1. Ent. r ha I saasa, or complication that ceused the death. Shock, or ha int feitura. List only ona cause on each line. ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximete intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting In daeth) Sequantially list conditions, if any, laeding to immadieta ceusa. Entar Undartying Causa (Diseese or Injury that initiated avants rasuiting in death) Last Dua to (or as a consequence of) Dua to (or as a consequance of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 1 Yes 2No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy parformad? 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

*nature!', or items 23s or

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or iter any Injury or other treumatic event, the Medical Examine page.

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

with the Maryland

death

physician end s tha burial-transit 88 980 signed by the should I hes 82

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

Hospital

funeral After efter death. 5

s certificata he this

Physiclan/Medical Be To

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Completed

Certification:

edical

24 hours efter Funeral Dire letely filled in b within 24 hor To the Fune completely fi

State Registrar

31. Date filed

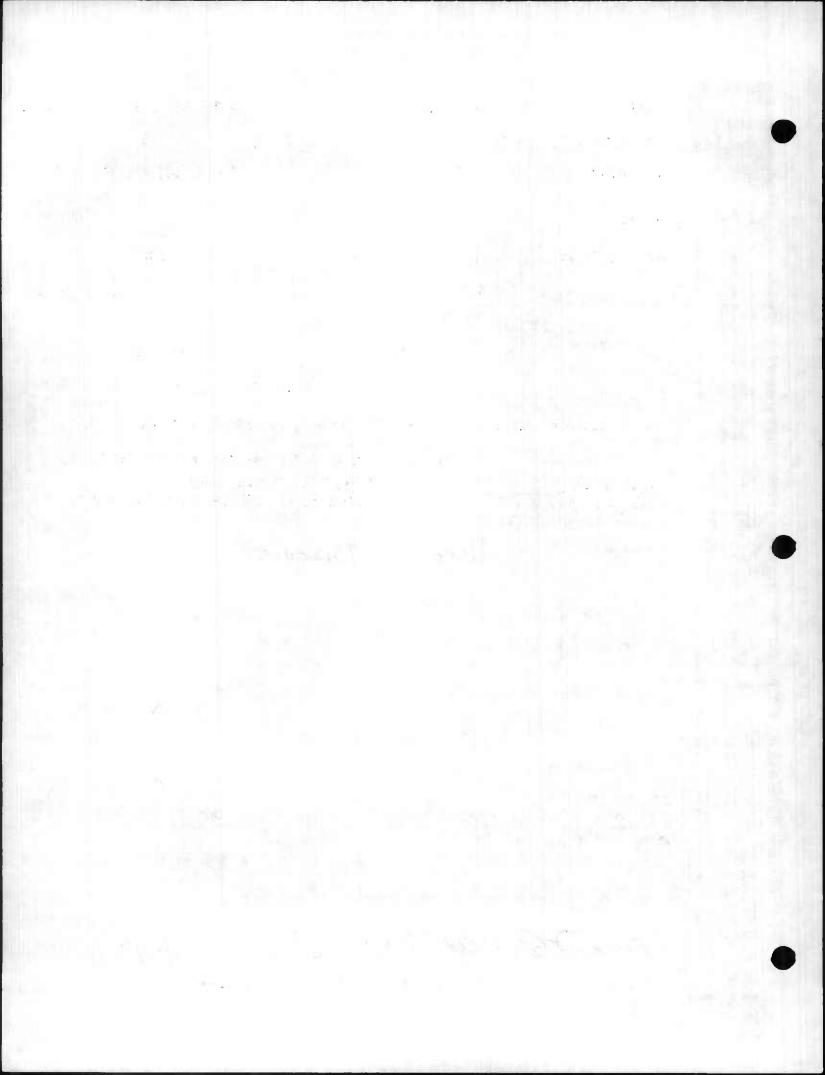
25. Wes casa raferrad to medicel examiner? 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Nasidence 8 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accidant 5 Panding invastigation 1 Yas 2 No 6 Couid not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 3 ☐ Suicida Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 29a. Cartifiai 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the causa(s) and manner stated. (Check only one)

29b. Signature and title of certifi-

29d. Daja signed (Month, Day, Year)

30. Neme and eddress of a rson who completed



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dauscn Anthony 8:35 AM March 23 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY Johns Hopkins Boyview Medical Center Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. SEPT. 14, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**XM 2□ F 213-05-5492 83 Yrs MARYLAND Director Usual Residenca of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show MD CITY 1 Yes 2 □ No Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with intent of Health and Mental Hygiene.
snt: If Item 27 is marked other then "natural", or Iteme 23a or inty or other traumatic event, tre Manical Examinations 1024 SOUTH DECKER AVENUE 21224 U.S.A. by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1X1 Yes 2 □ No If Yes, Give 42-46 Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) BOOKKEEPER ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) JACOB JAMES DAUSCH ANNA SAVER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET SHINSKY 514 S. 45th STREET BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or MOST HOLY REDEEMER CEM 3/27/98 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 23a. Part 1. Enter the disease, or complications that cause shock, or heert fellure. List only one cause on each 901 S. CONKLING STREET BATLIMORE, MD 21224 enter the mode of dying, such as cardiac or respiratory errest. Physician /Medical Immediate Cause (Final Myocardial Infarction

Due to (or as a consequence of): 2 days disease or condition resulting in death) Examiner Coronary Artery Disease
Due to (or as a consequence of): is years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieled events resulting in deeth) Last Physician/Medical The law requires that the death certificate Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Prostate Cancer Records, 24b. Were autopsy findings avaitable prior to completion of cause of death? Completed 24a. Was an autopsy performed? Hypertension 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 940 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical vithin 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 97017 March 23, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) APR 01 1998

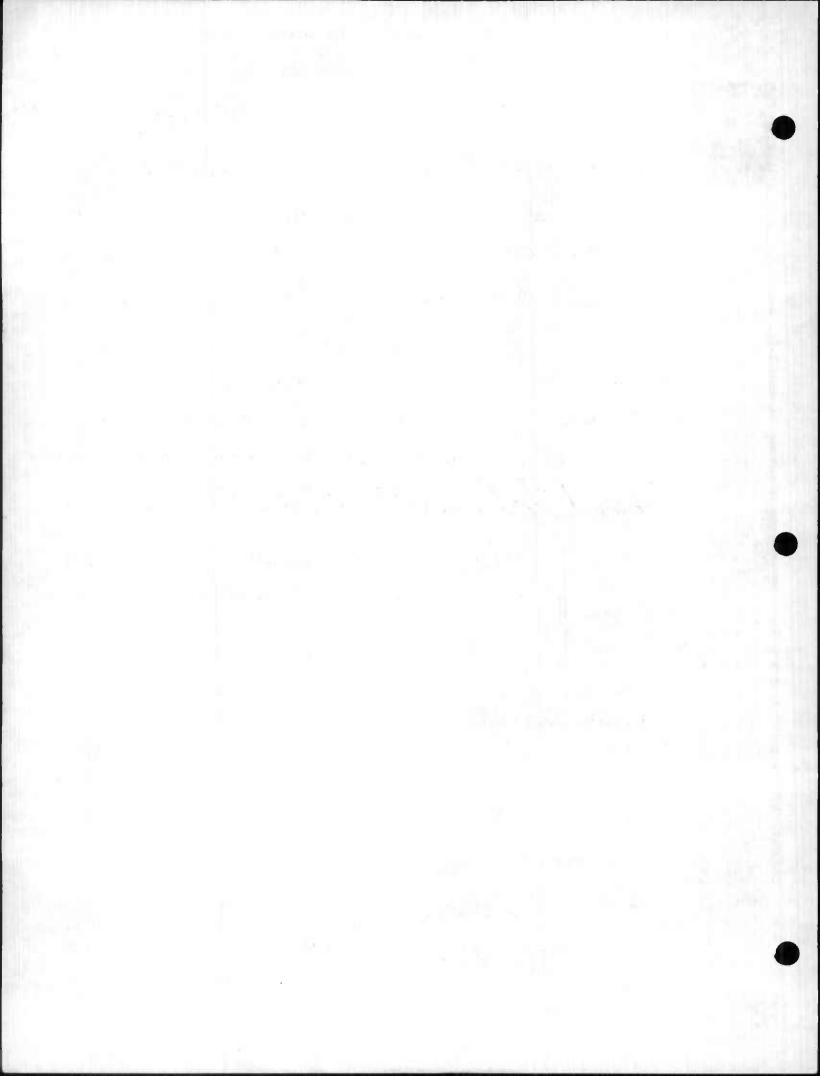
Susan

Hobbs M.D. 4940 Eastern Ave 32. Registrar's Signature whia Davidson Randalle

Baltimore, MD

P.O. Box 68760.

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0256 Certificate of Death Item#26 per Phy G758 4/1/98 EW 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death March 30, 1998 **Physician** Walter Fisher Dorman 10:30 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Examiner Countryside Protective Care Carrell Hampstead 5. Socief Security Number 218-01-0700 7. Age (In yrs. lest birthday)

7. Yrs. If Undar 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer)
April 28, 1912

9. Birthpleca (St Country)

Maryland Birthpleca (State or Foraign Country) **Funeral** Months Deys Hours Min 10€M 2□ F Director Usual Residence of Decedant with the Maryland r 28a-f show 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore Reisterstown 1 Yes 2 No Director 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? I is marked other than "natural", or items 23s or traumatic event, the Modical Examiner must be a 8 W. Chatsworth Ave. 21136 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiena.
Int: If Item 27 Is marked other than "natural; or Items 23s Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Electrical Supply President 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middla, Last) Martin Dorman Estelle Fisher 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Steta, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 7410 Race Rd., Hanover, Md. 21076 William G. Dorman Item 2 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, Steta Important: If its any injury or oth 20e. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory March 31, 1998 Baltimore, Md. 22. Name end Address of Fecility

Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate tntervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) 2-540 Examiner to (or es e consequence of): Physician/Medical Examiner law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequança of): P.O. Box 68760, Dua to (or as e consequenca of) 88 esn ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert f. 3 □ Probably 4 Unknown 1 Yes 2 No Division of Vital Records, ģ 24b. Were eutopsy findings aveileble prior to 24e. Was en eutopsy performed? Completed completion of cause of deeth? page 2 has 1 ☐ Yes 2 No certificata 1 ☐ Yes 20 No or Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Notesidence 6 Other (Specify) Assisted 10 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this s funeral 28e. Dete of Injury (Month, Dey Year) 27, Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After Naturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A Investigation 2 Accidant 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) end menner es stated.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier To the Hosp within 24 hou To the Fune completaly fi Medicai (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signeture and the of cartifier 29c. License number 3/30/98 address of person who completed cause of deeth (Item 23a) (Type, Print) HAMPSTEAD MD 21074 4231 NORTHWOODS TRAIL 32. Registrus Signature Guina Davidon 31. Data filed (Month, Day, Year) State APR 01 Registrar

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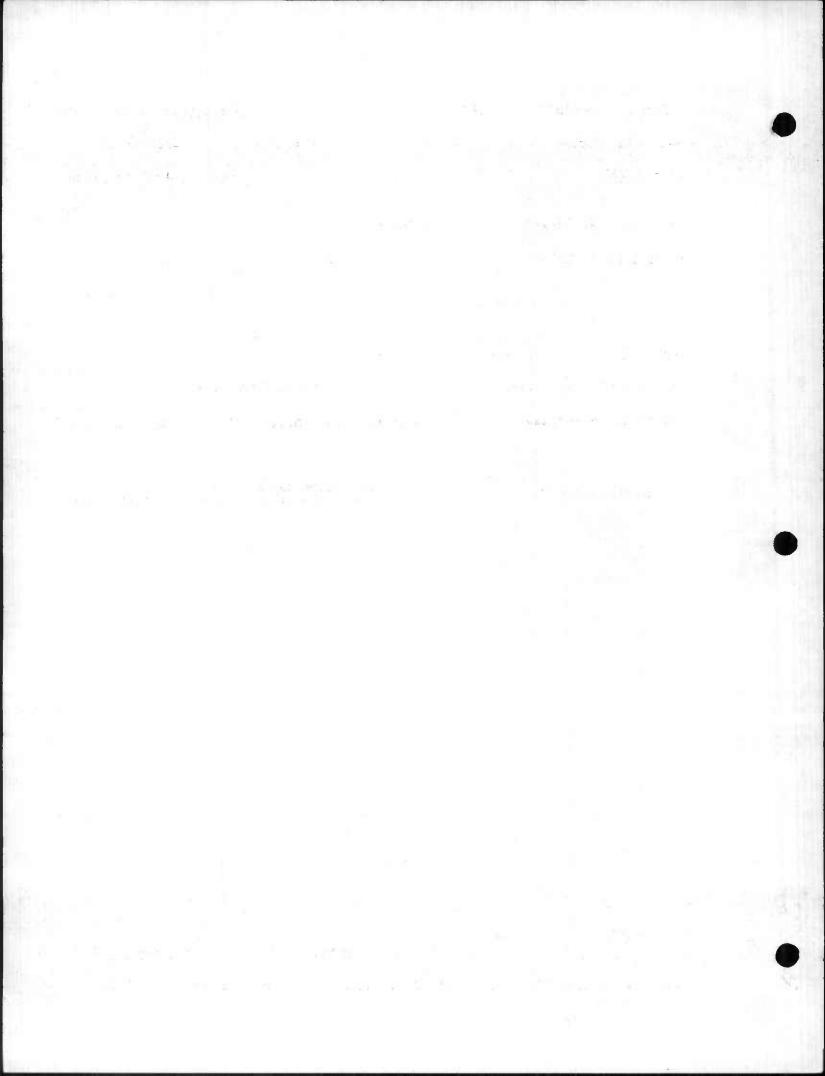
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Department of important: If It eny injury or o		21. Signeture of F Ronald	unerei Service L S. Wade	Licensee per	r vr		Stat	e Ana	ss of Fecility tomy Board Itimore St.	Ra1+	imore,	Mary	vland.	21201
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State of Maryland / Department of Health and Mental Hygiene 4

	I	te	m 29b c Per PHY Fi	lm G758 4-	1-98 r	Certificate of	f Death		Reg. No.		0230
	Physic		1. Decedent's Nama (First, Middle, La	st)				2. Date of Dea Month	Day	Yeer	3. Time of Death
	/Medi		Roy W 4a. Facility Nama (If not institution, giv		ns		4b. City, Town, or L	March 8		of Dooth	11:02 p.m
<i>)</i>	Exami	ner	Edw. W. McCready		Joonita	1	Crisfie		Somer		
İ	Funeral Director				(In yrs. last bii		if Undar 24 Hrs.	8. Date of Birt	h	9. Birthp Coun	laca (State or Foreign try) Vland
	P .		Usual Residence of Decedent								
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	the M	ecto	Maryland Somer			10f. Zip Code			10g. Citizen of V	What Caus	
	ath with 23a or	Funeral Director	4599 Pump House				21817		USA		
020	be filed within 72 hours efter death with the Manyland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exam her must be notined at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forcas? 1 M Yes 2 □ N if Yes, Giva Year or Dates:	·World	13. Was Decedent of If Yes, specify Cu		pecify Yas or No- Rican, atc.)		e - Americ ck, White, Whi	etc.
ה כ	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usual Occi	upation e during most of work	kina	16b. Kind of Bu	usiness/inc	lustry
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6			Robert H. Bra 23a. Parl. Entar tha diseasa, or com shock, or heart failure. List only		the death. Do				,	21	Approximate interval Between
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5	Attending Ph or death. actor: After th by the funeral	ertification:	27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation			Time of njury M 1[ury et ork? □ Yes 2 □ No	28d. Describe h	now Injury occur	red	
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	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	edicai C	29a. Certifier (Check only one)	ysician: To the best on ninar: On the basis of end manner sta	examination an	e, deeth occurred at the d/or investigation, in my	time, dete end plece, opinion, deeth occur	and due to the ored et the time, o	cause(s) and ma date end place,	anner es si and due to	ated. the ceuse(s)
	To th To th comp	Me	29b. Signature and title of certifier	•			nsa number		29d. Data signe	d (Month,	Day, Year)
J			30. Name and address of person who	completed ceuse of da	ath (Item 23a)				., -, -		
			Dr. T. Kanchana,	Main St.,	Crisfi	eld, Md. 21	817				
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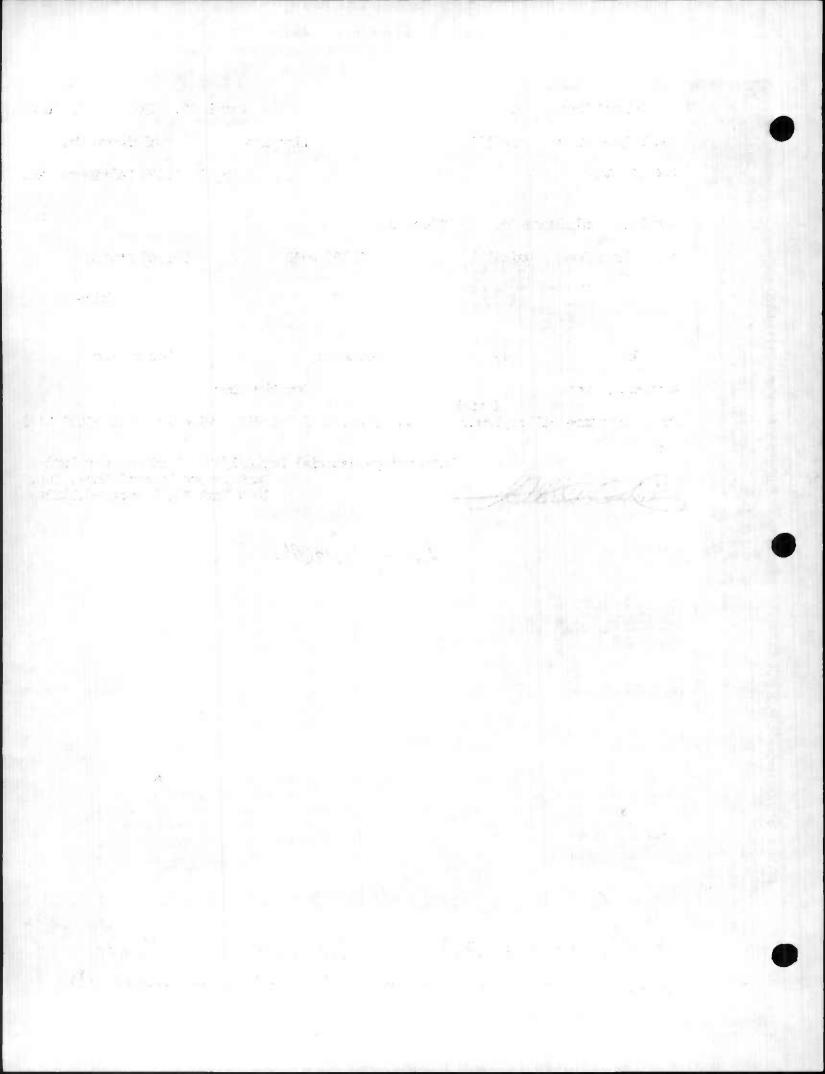
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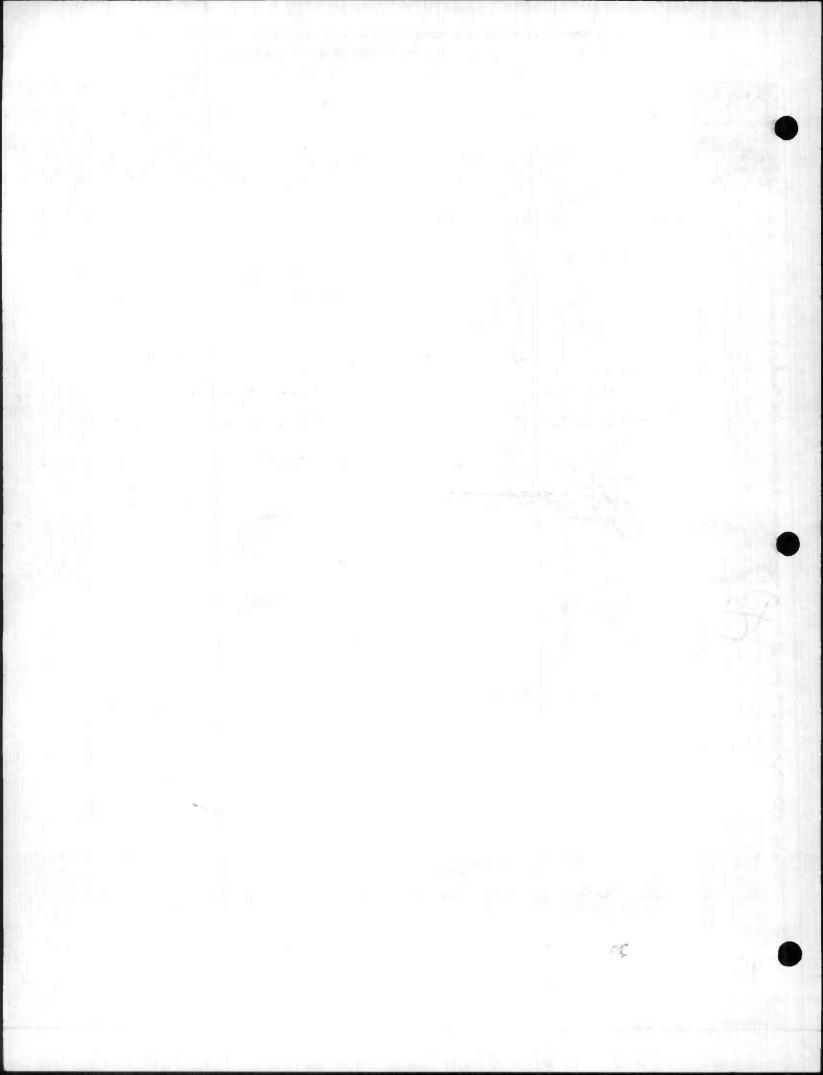
Physician			Ce	rtificate of	Death		g. No. 🧷 ()	1025	}
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/Medical	A. Richard Fromm					March 29		12:20	AM
Examiner	4a Facility Nama (If not institution, give	re streat end number)			4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth	
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28a-f show notified at rector	Tod. Steta Too. County		Toc. Ony, Town or Ec	Joanon				1 ☐ Yas	
recto	Maryland Baltimo	ore Co.	Timoniu						200
0 K 0	10e. Street end Number			10f. Zip Code		10	g. Citizen of W	/het Country?	
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by F	1 Nevar Married 2 Married	1 Yes 2 No		1□Yes 25 No	Specify:		Specify:	White	
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du	Etementery/Secondary (0-12)	Coltege (1-4or 5+	.)						
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Be							aloun ournam	ω)	
10	August R. Fromm				Dorothy		011	0 7. 0. 1.	
any injury or other traumatic event, the once. To Be Com	19e. Informant's Name/Relationship (,		et end Number or Run				2002
191	Mrs. Nancy (nee Mi	Liter) From			oad Unit#1			Md. 21093-8	1003
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	4 ☐ Donetion 5 ☐ Other (Special							e, Maryland	
any Injury pace.	21. Signature of Euneral Service Licer	Shall	2	2. Nama and Addr	ess of Fecility Ruc	k Towson	Funera	al Home, In	ic.
ह व	Made My	STORE STORES	7		105	0 York F	d. Tows	son, Md. 2120)4
the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Oue to (or es e conse						
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e Eo						1□ Ye	s 2 No	1 🗆 Yes 2 🗆 1	No
Be C	25. Was case referred to medical				26. Plece of Deet	h (Check only one	9)		
el director, page : To Be Com	examiner? 1 ☐ Yes 2 No	Hospitel: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3D DOA	thor	me 5 Reside		er (Specify)	
n: T	27. Manner of Deeth	28e. Dete of Injury	28b. Time o			28d. Describe ho			
atio ott	1 Accident 5 Pending invastigation	(Month, Day	Year) tnjury		Yes 2□No				
Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, ferm, st (Specify)	reat, fectory, office	•	28f. Location (Str. City or Town	eet and Numb , State)	er or Rural Route Numb	ver,
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Medical	29b. Signature and Title of certifier	completed cause of da	Peth (Itam 23e) (Tyne	D3	30929		3/3	8/97	
pletely fil	29b. Signature and Tile of certifies	completed cause of de	eth (Item 23e) (Type,	D3	30929	DALL	3/3 CELAN	0/97 00, MD	



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State of Maryland / Department of Health and Mental Hygiene

						Certificate o	f Death		Reg. No.		0260
			1. Decedent's Neme (First, Middle, I	ast)				2. Dete of D Month	eeth	Voor	3. Time of Deeth
	Physici /Medic		MARGARET JANE	FONTZ				MARCH	Dey 28, 19	Year 998	12:18AM
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			913 TIMBER RI	OGE DRIVE			HANOVE		ANNE A	RUND	EL
	Funeral		Social Security Number 6.	Sex 7. Ag	ge (In yrs. lest bir	Months Dev			irth lay, Year)	9. Birthpl Coun	lece (Stete or Foreign stry)
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	pue A.		Usuei Residenca of Decedent 10e. State 10b. County		10c. City, Town	n or Location				10	0d. Inside City Limits
	Wery!	0	MARYLAND ANNE A	RUNDEL	HANOVE	R					1 ☐ Yes 2 ☒No
	sth with the Meryler 23s or 28s-f show	Funeral Director	10e. Street end Number			10f. Zip Code	0		10g. Citizen of W	/het Coun	itry?
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	Seeth Fre 2:	era	913 TIMBER RIDG	12. Wes Decedent	Ever In U,S.	13. Was Decedent of If Yes, specify C	of Hispanic Origin?	(Specify Yes or N	U.S.A. 0- 14. Reca	a - America	an Indien,
0	fler dee	Fur	1 Never Merried 2 Married	Armed Forces? 1 Yes 27 it Yes, Give				erto Rican, etc.)	Blac	k, White, e	etc.
020	urs off	by	3 ☐ Widowed 4 ☐ Divorced	it Yes, Give Yeer or Detes:		1 ☐ Yes 27 N	lo Specify:		Specify	WHI	TE
21215-0020	within 72 hours efter deeth with the Meryland ane. than "natural", or items 23a or 28a-f show ha Medical Examiner must be notified at	Completed	15. Decedent's	Education	16a.	Decedent's Usuei Occ	cupation	and in a	16b. Kind of Bu	siness/Ind	dustry
2	iene. Than "n	ple	(Specify only highest (Elementery/Secondery (0-12)	College (1-4or	5+)	(Give kind of work dor life. DO NOT use ret	ired)	Orking			
	od with giene.	Son	12	N/A		HOMEMAKER			OWN HO	ME_	
pu	be filed itel Hygi d other event,	Be	17. Fether's Neme (First, Middle, La	st)			18. Mother's N	eme (First, Middle	e, <i>Maid</i> en Sumem	Θ)	
Maryland	should be filed v nd Mentel Hygie marked other t umatic event, th	2	JOHN THOMAS BENN	ETT			LILLIAN	L. STEV	VENS		
Jar	S sh end end s m		19e. informent's Neme/Relationship			. Mailing Address (Stre					
	E = O L		LAWRENCE E. FONT:	Z-HUSBAND		3 TIMBER R		-	VER, MARY		
0			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	Removel from State	comete	Disposition (Neme of y, cremetory or other p	oleca)	Date	20c. Location -	City or To	wn, Stete
Baltimore,	permit. Peges Depertment of Important: If I any Injury or once.		4 Donetion 5 Other (Spec	•	GLEN H	AVEN MEMOR		4/1/98	GLEN BUR	NIE,	MARYLAND
Sal	ermil Seper Trpor ny Ir		21. Signature of Ameral Service Lic	ansee	_	22. Name end Ad	dress of Fecility S I	NGLETON	FUNERAL	HOME	. P.A.
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		10	resulting in death)		Due to (or es e	consequenca of):					J
-	DA	Examiner		b							
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00	v requir been s should	lete						per	formed?	cor	mpletion of cause deeth?
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of	문문	-	27. Menner of Deeth	28a. Dete of inju		Time of 28c. In	njury et Vork?	-	how injury occurr		77
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SIS	Attendition of the sector: A by the fu	Hice	3 ☐ Suicide 6 ☐ Could not determine	A 286. Piece of in	jury - At home, te	rm, street, tectory, offic	се	28f. Location	(Street and Numb	er or Rura	I Route Number,
ă	of or Att	Certification:	4 Li Homicide	building, et	c. (Specify)			City or 1	own, Stete)		
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	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b	edical	(Check only 2 Madical Ex	end menner st	t examinetion en eted.	d/or investigetion, in m	y opinion, deeth oc	curred et the time	, dete end pleca, e	and due to) the ceuse(s)
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	,		man	non		D	39505		marc	43	0,1998
	10		30. Neme and address of person wh	completed cause of	deeth (item 23e) ((Type, Print)					
	10		. 1	1 0000	nD. 14	OLB S.C	RAIN H	16HWA	4, GLEN	BURN	0, 1998 46,m021061
	Sta	ite	31. Dete tiled (Month, Day, Year)	32. Regist	rer's Signeture						
	Registr	ar	APR 0	1 1998	guha Das	ridson-Randall	2				



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Year Lowse Tiorelli 03 98 10:17 Am 26 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PG Hospital Clanton nd Southern Mayb If Under 1 Year 8. Date of Birth (Month, Day, Year) June 13, 1919 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys 1□ M 2🛣F Hours Yrs North Carolina 78 243-26-0636 Usuel Residence of Decedent 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 Yes 2 No Maryland Prince Georges Forestville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7420 Marlbor Pike 20747 United States Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritei Status 1 □ Yes 2 🗓 No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Waitress Food Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) O.A.Register Repsie Pope 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Fiorelli / Son 6710 Conway Avenue, Takoma Park, Md. 20912 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 4/1/98 Suitland, Maryland 21. Signeture of Funeral Service Licens 22. Name end Address of Fecility ALEXANDER S. POPE FUNERAL HOMES 11315 Lockwood Dr., Silver Spring, Md 20904 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate fntervei Between Onset end Deeth Due to (or es e consequence of): Dreumonia Due to (or es e consequence of)

Physician /Medical Examiner

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Hospital or Attending Physician:

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10a. Stete

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1 and 2 should be filed within 72 hours after. Heelth and Mantal Hygiana. 8m 27 Is marked other than "natural", or ite

permit. Pages 1 end 2 t Department of Heelth en Important: If Item 27 Is I any Injury or other trau

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be nutthed at

the Maryland

Examiner Physician/Medical À Completed Be Certification: To

Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert If. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveitable prior to completion of cause of death? 24e. Wes en eutopsy performed? 20 No 1 Yes 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medical 28. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Neturei 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Plece of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner as steted.
2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated. 29a. Certifier

29c. License number

026352

29d. Dete signed (Month, Day, Year)

State Registrar

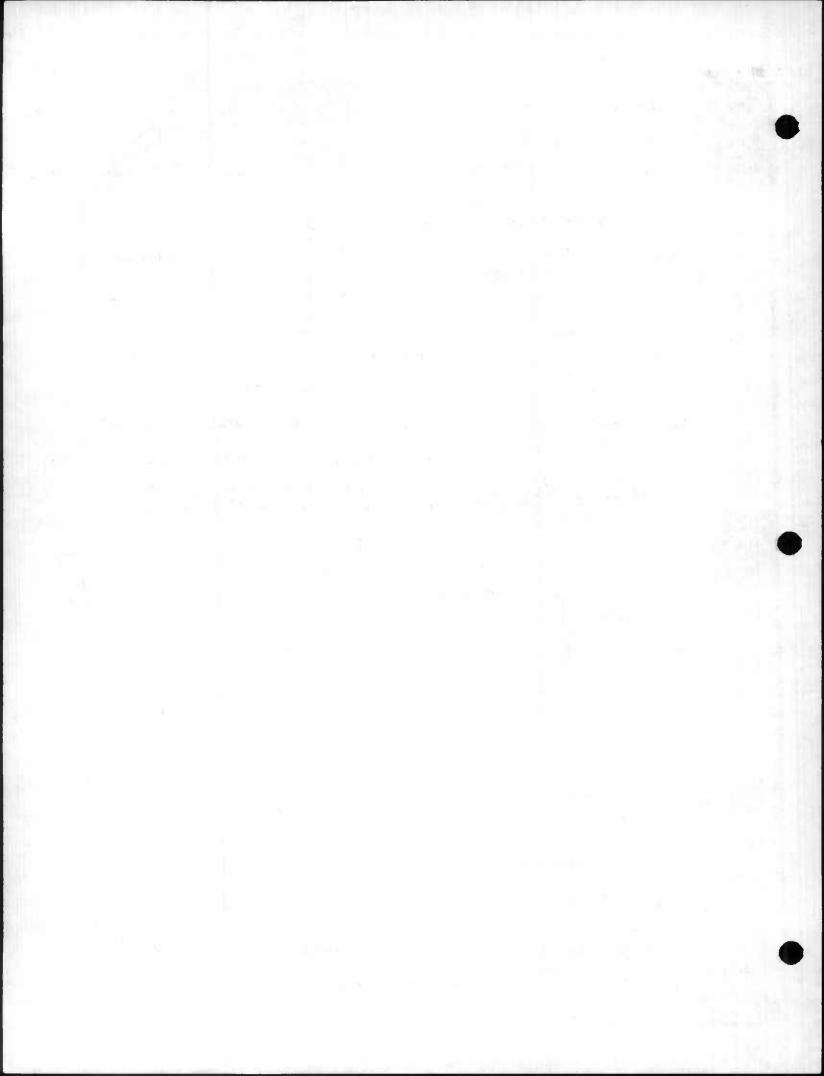
31. Dete filed (Month, Day, Year)

29b. Signeture and title of certifier

O.L. Haye

9131 RECETAWAY Rd Clinton md 20735 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day Month March 28, 1998 ZONA E. FEARINS 2:15a.m. 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Cherrywood Manor Nursing Center Baltimore Reisterstown 8. Date of Birth (Month, Day, Year) Jan 27, 1922 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Months 1 ☐ M 2 🛣 F Days Hours 76 Yrs. Maryland 218-14-7049 Usual Residenca of Deceden 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2€No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 12328 Timber Grove Road IISA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 ☐ Yes 2 🖾 No It Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) Telephone Operator State of MD 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Harrison M. Neuhauser Minnie Horn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12328 Timber Grove Rd., Owings Mills, MD 21117 Susan J. Miller - Daughter 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other pieca) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremation Services 3/31/98 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funerel Servica Licensee 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death 3700 Immediate Cause (Finel disease or condition resulting in deeth) a End Stage Pend Districe Due to (or as a consequence ot): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Horsing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner**

Examiner

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? Is marked other than "natural", or items 23e or 28a-f show trsumstic event, the Madical Examiner must be notified at

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P.O. Division of Vital Records, or Attending Physician: effer death. Director: After this certific 24 hours Hospital To the Hosp within 24 ho To the Fune completely fi

> State Registrar

5 Pending

Investigation

6 Could not be determined

28e. Dete of Injury (Month, Dev Year)

28b. Time of

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

1 Tes 2 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Minkou 20 MA.A

31. Date tiled (Month, Dey, Yeer)

1 Yes 2 LNO 27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 Aocident

4 Homicide

(Check only one)

29b. Signeture end title of certifier

Pegistrar's Signature Anders Anders

Caurin Mi Alimodens the common that entered and energy to early Many remains that After the contract of the second beautiful and

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth Month **Physician** AUGUST WILLIAM GRUND 7:30 p.m March 1998 /Medical 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not Institution, giva street and number). Examiner HRundel Hospital Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Data 5. Sociel Security Number 8. Data of Birth OCT 28 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-05-7930 1 JM 2 □ F 82 1915 BALTIMORE, MD. Yrs. Director Usuel Rasidence of Dacedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MARYLAND ANNE ARUNDEL 1 Yas 2 No MILLERSVILLE Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 102 ROL PARK TRAILER VILLAGE Funeral 21108 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Naver Merried 2 Married 1 √ Yes 2 No 1941 – If Yas, Giva Yaar or Datas: 1945 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE by 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) ADMINISTRATIVE RETAIL SALES 12 N/A17. Fethar's Nema (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Surname) h end Mental FRITZ GRUND SOPHIE HEISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health e Important: If Item 27 is any injury or other tra-DARLENE GRUND-NEICE 2863 COUNTRY LANE ELLICOTT CITY, MARYLAND 21042 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata MBurial 2 Cramation 3 Ramoval from Stata 4 Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 4/3/98 GLEN BURNIE, MARYLAND 21. Signatura of Funaral Service Lange 22. Nama and Address of Fecility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE., S.W. GLEN BURNIE, MARYLAND 21061 Enter the disaasa, or compilcations thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata intarval Batw Onset end Death **Physician** /Medical dlete Causa (Final neumonia disaasa or condition rasulting in death) **Examiner** Examiner Sequantielly list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Diseesa or injury that initiated avants resulting in daath) Lest Due to (or as e consaguança of): Physician/Medical Dua to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? s been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown by 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 Yas 2 No Division of Vital 25. Was case raferred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No this uneral 27. Mennar of Death 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 X Natural 5 Panding is after death. 1 ☐ Yas 2 ☐ No 2 Accident Invastigation 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in edical 29a. Cartifian To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as steted.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) 29b. Signature a 29d. Deta signad (Month, Day, Year) ditte of certifier 29c. License number March 31, 1998 M. V rass of person who complated causa of death (Item 23a) (Type, Print)

North

(12. Registrar's Signatura

Juha Davidson-Randelle

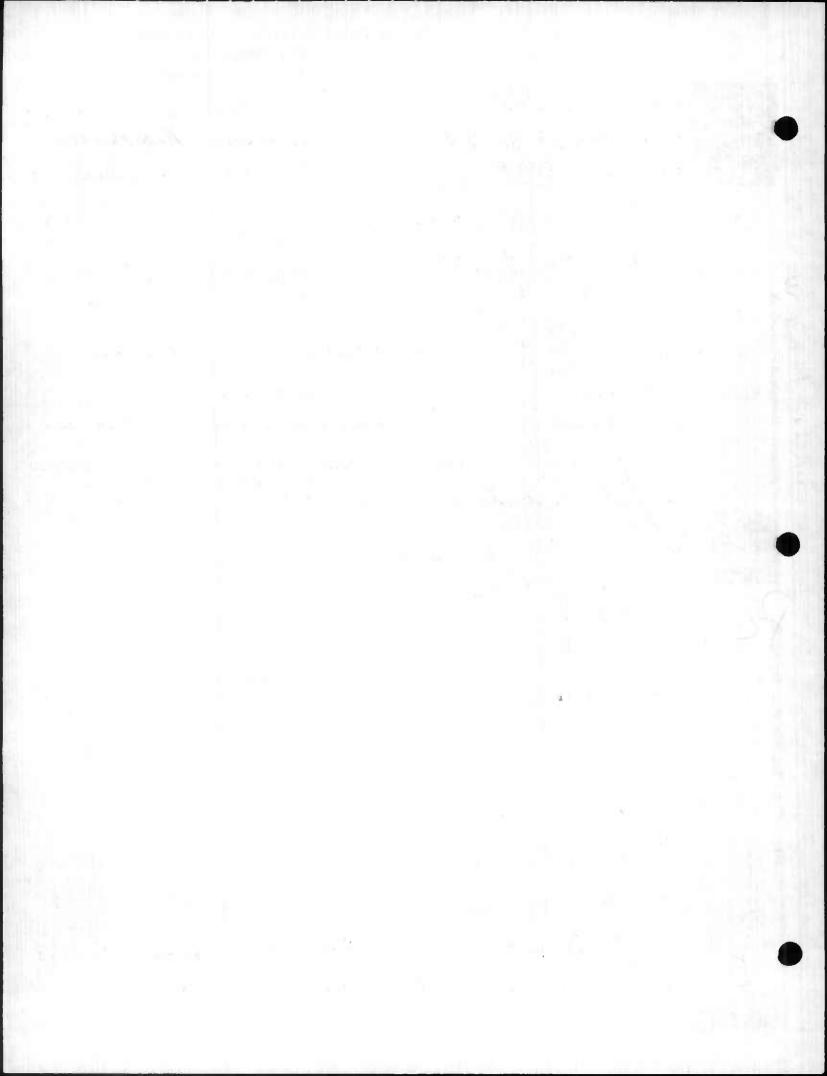
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State

Registrar

31. Date filad (Month, Day, Year)

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Please Type or Print in Biack Indeiibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health at Certificate of Death	nd Mental Hygiene 9 8	0264
CVITHED	2. Date of Deeth Month Dey Year MADCH 26 1009	3. Time of Deeth

DS155 | MARCH 27, 1998

CLAIN Highway Suite 602, Glen Burnie 42 204

Exa

Fun Direc

"natural", or items 23a or 28a-f show

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Physic /Medi Exami

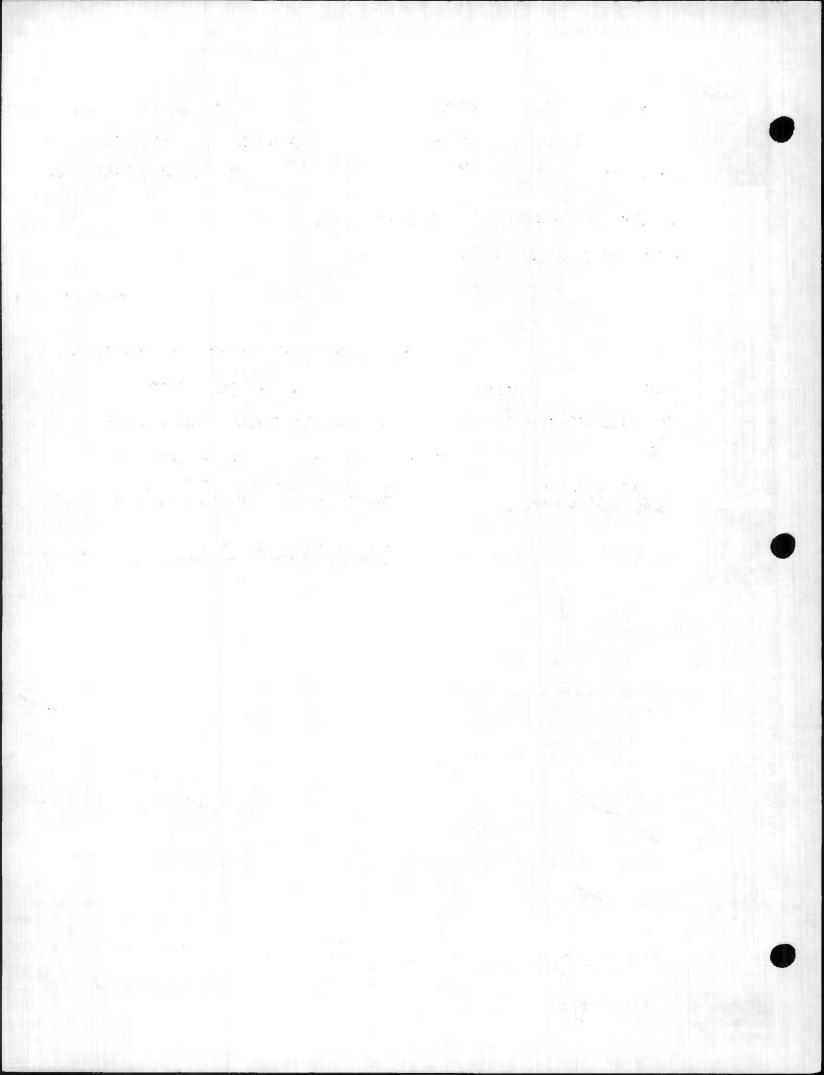
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burla-fransit Division of Vital Records, P.O. Box 68760,

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12 Registrar's Signeture

State Registrar 29b. Signature and title of certifier

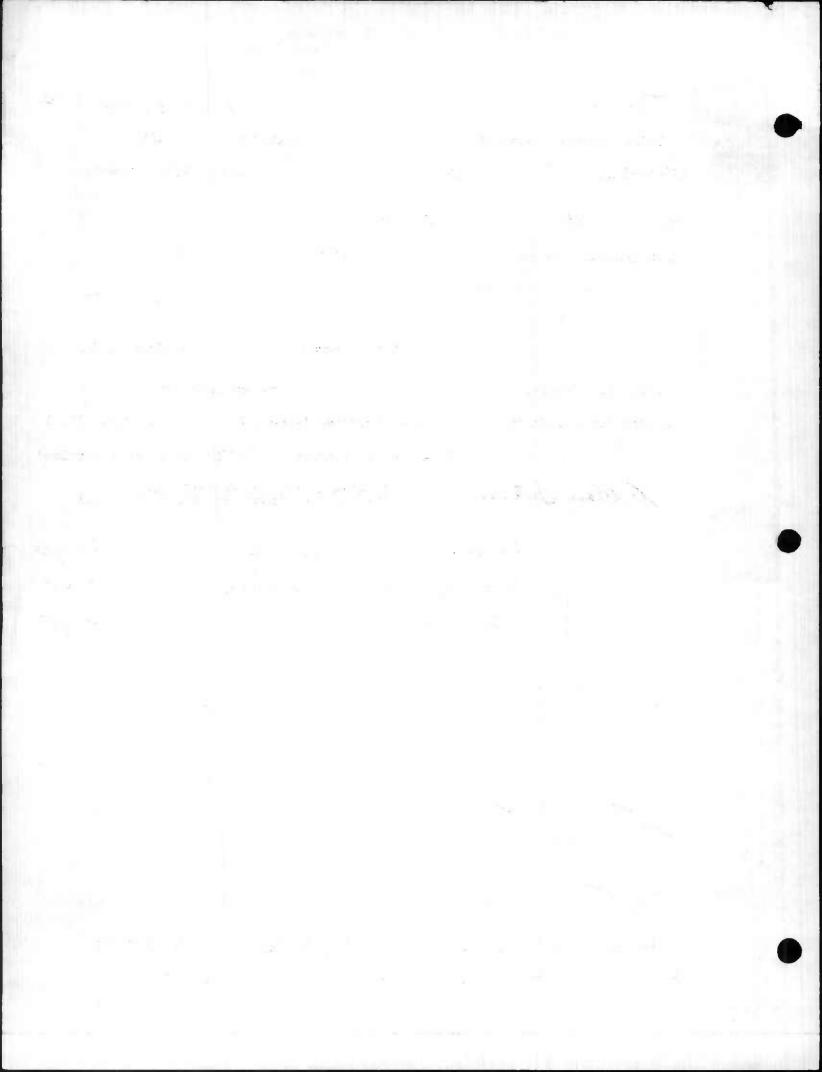


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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month ARCH **Physician** Gerecht AM homas 27 1998 /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva straat and numbar) 4c. County of Death **Examiner** Baltimore Union Memorial Hospital Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) if Undar 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2□ F Days Months Hours Yrs. Director 57 Dec 3, 1940 Maryland 218-36-1821 Usual Rasidance of Dacedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 2 □ No Director N/AMaryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 23a or U.S. A 21211 Funeral 2070 Rockrose Avenue Herrs . Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amaricen Indian, 11. Marital Status Black, Whita, atc. filed within 72 hours after □Yas 2](No Yas, Giva 1 Navar Married 2 Marriad ŏ 21215-0020 1 ☐ Yas 2X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorcad natural', Year or Dates: 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry ai Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) B. Green & Co. Warehouseman altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Department of Health and Mental important: If Itam 27 is marked or any injury or other traumatic even Pages 1 and 2 should be 2 Anna Greensfelter Carl A. Gerecht 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2070 Rockrose Avenue, Baltimore, Maryland 21211 Bertha Gerecht (Wife) 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata Green Mount Cemetery 3/30/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician /Medical Immediata Causa (Final 1 schemic Cardio mya disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquance of) Physician/Medical Examiner Curangry The law requires that the death certificate be executed for use as the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and of Vital Records, P.O. Box 68760, labe les that initiated avants rasulting in death) Last Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to completion of ceuse director, page 2 should Completed 24a. Was an autopsy of daath? After this certificate has 1 Tas 2 No 1 Yas 2 No ding Physician: Be 25. Was casa rafarrad to madical 26. Placa of Daath (Check only ona) Hospital: 2 ER/Outpatiant 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To uneral 27. Mannar of Beath Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred sipn Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant To the Hospital de Men within 24 hours stief des To the Funeral Director completely filled in by the 24 hours affer deal Furevel Director 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 I Homicida Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar Medical (Check only 29b. Signature and titla of contifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number 30 Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) SICHARD 730 DIAMONS 32. Registrar's Signatura 31. Data filad (Month, Day, Yaar) State 21211 APR 01 1998 who Davidson-Randall Registrar



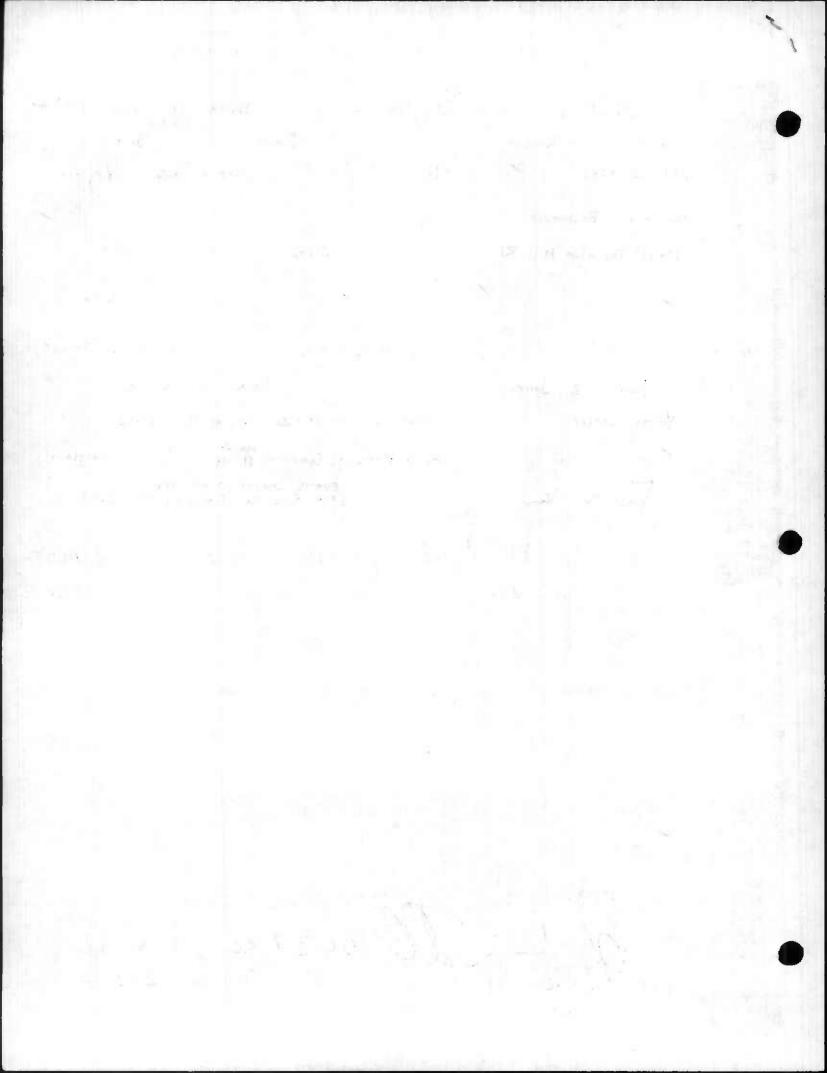
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time La Death **Physician** Month 5:40 AM March 28 /Medicai 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give straat and number) 4c. County of Death Examiner Manor Care -Towson Ruxton Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Couptry) **Funeral** Months Days Hours 1□ M 22 F 91 2808 Yrs 22 Director 8 Yirginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If tiem 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be nothing at Baltimore SOArKS 1 Yas 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 21152 Thornton Mill Rd 73911 deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. should be filed within 72 hours after of Mental Hygiene.

marked other than "natural", or iter 1 Navar Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give` Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: White ð Specify: 3. Widowed 4 □ Divorced Completed 15. Dacadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Black the DECKER Clerk permit. Pages 1 and 2 should be file Department of Heelth end Mental Hy, important: If item 27 la marked other any Injury or other framework. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Surname) SArAh R Jones JAMIES 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carter Sparks Velma 21152 13921 Thornton Mill RJ. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from State SPARKS 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 31 1998 EVANS Char.
2725 York Rd. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility of Chimes Chapel 2325 21093 Timonium MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Dua to (or as a consequence of): Box 68760, ettending physician for use es the burie The law requires that the death certificate be Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contributa to the cause of death? the signed by t d be detach 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performad? peen: page 2 22 No certificate 1 Yas 2 No Division of Vital Hospital or Attanding Physician: 24 hours efter death. director 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 3 Sulcida 6 Could not be 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 29a. Certifier investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29b. Signatura and tule of o 29d. Date signed (Month, Day, Year)

32. Registrar's Signature

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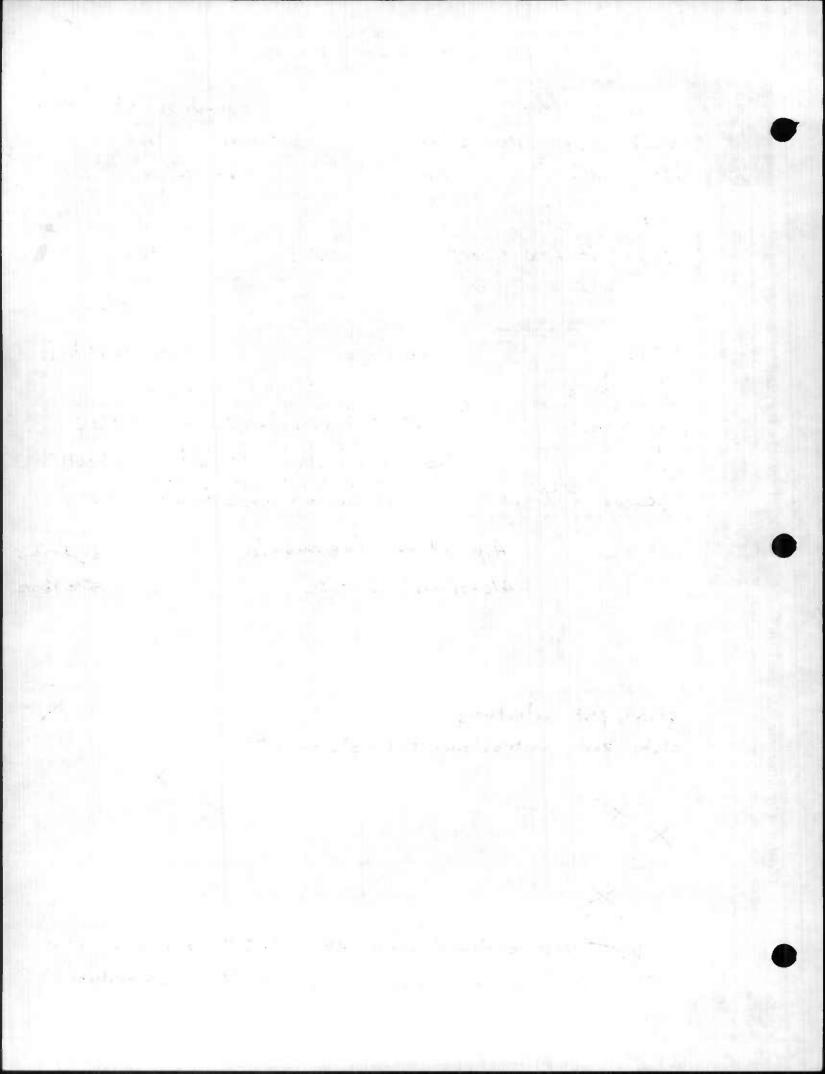
State Registrar 30. Name and add



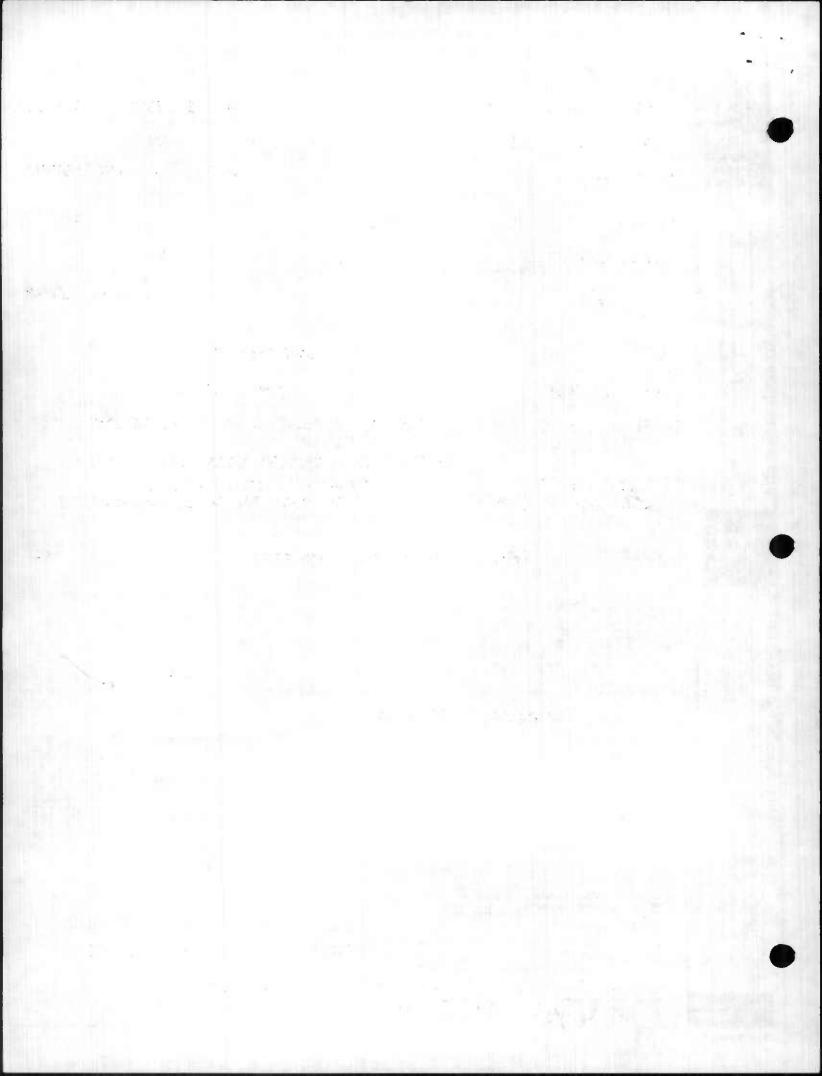
Thomas Heath

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland / Departm Certific	nent of Health and N cate of Death	Mental Hygien Reg. N	98 1	0267
Physician	1. Decedent's Name (First, Middle, List) Thomas Heath		2. Dete of Deeth Month	Dey Year	3. Tima of Deeth
/Medical Examiner Funeral Director	4e Fecility Name (If not institution, give street and number) 3521 E HOFFMAN STREET 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) If U Mon 20 F 86 Yrs.	Inder 1 Year if Under 24 Hrs.		NG 9. Birth	plece (State or Foreign ntry)
ahow ed at	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Baltimo				10d. Inside City Limits 1 √Yes 2 □ No
natural', or items 23s or 28s-f show dical Examiner must be notified at eted by Funeral Director	10e. Street and Number 10f	1. Zip Code	10g. C	Citizen of Whet Cou	
at, or items 23s or 28s-fa Eserciose must be notified by Funeral Director	2521 E. Hoffman Street 11. Maritel Status 1 Never Married 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 1 Yes 7 Detes:	Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Rece - Ameri Bleck, White, Specify:	
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it: if itam 2 y or other	19e. Informent's Name/Reletionship (Type, Print) (W) fe) 19b. Meiling Add 252 E 20e. Method of Disposition 1	Hoffman Stree	Baltimon Dete 200.	e Md. 21 Location - City or T	213
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ta has been sig	status post Gastrostomy tube	placement	24e. Wes en eu performed'	7 0	Vere eutopsy findings vallable prior to ompletion of ceuse f deeth?
al dire	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐	DOA Other: 4 Nursing H	ome Sesidence 28d. Describe how in		ify)
within 24 hours after death. To the Funeral Director: After the complately filled in by the funeral Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of fnjury - At home, ferm, street, fa building, etc. (Specify)		28f. Location (Street City or Town, Sta	ate)	
within 24 ho To the Fune completely f	29a. Certifier Certifying Physician: To the best of my knowledge, death occu (Check only one) Certifying Physician: To the best of my knowledge, death occu end manner stated. 29b. Signature of certifier	etion, in my opinion, deeth occur	rred et the time, dete e	Dete signed (Month	, Day, Year)
3	30. Name and advess of person phy completed ceuse of deeth (Item 23e) (Type, Print) Todo Griffith Johns Hopki	RES-00	600yout	hwolfest	1998 Biltimore
State	31. Dete filed (Month, Dey, Year) ADD 0 1 1998 June Landon Andere				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death cedent's Neme (First, Middle, Last) MARCH 28, 1998 **Physician** 10:30 A.M. DON CARLOS HULL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) **Examiner JOSEPH** RICHIE HOSPICE BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth Month, Day, Year, APRILIZ, 1933 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days WEST VIRGINIA 64 Yrs. 449-64-1861 **Director** Usual Residenca of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a, Stete 10b. County TY Yes 2 No Directo MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Peges 1 end 2 should be filed within 72 hours efter death with Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or amy injury or other treumente event, the Medical Examiner must be a pince. USA 1007 W. LAFAYETTE AVE. 21217 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 □ XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: AFRO. AMERICAN Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) UNITED STATES UNIFORMED SER. USAF 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JONES** LEONA JOHN W. 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4021 WARD CHAPEL ROAD, BALTIMORE, MARYLAND 21104 ERNESTINE K. McCOY SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST CEMETERY 4/2/98 OWINGS MILLS, MD. ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical 3YEARS CARCINOMA OF THE PANCREAS **Examiner** Due to (or es a consequence of): Physician/Medical Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1/ Yaa 2 No 3 Probably 4 Unknown DIABETES MELLITUS by 24b. Were eutopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed certificate has b lirector, pege 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOSPICE 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and manner es stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number Getting In D. D06933 MARCH 30, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN B. MACGIBBON M.D. 101 W. READ STREET, BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 14 La Davidson Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Dey 29 Month March 4b. City, Town, or Locetion of Deeth

Physician /Medicai Examiner

Funeral

Director

the Maryland "natural", or items 23a or 28a-f show death the Medical

21215-0020

Director

Funeral

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Completed

Be

filed within 72 hours after Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than " Baltimore, Maryland nt of Health a If item 27 is or other tra permit. Page Department of Important: If eny Injury or

Physician /Medical Examiner

Examiner Physician/Medical þ Completed Be Certification: To Athar after death Director: 6 Medical

To the Hospital of within 24 hours a To the Funeral D completely filled

to

Division

1. Decedent's Name (First, Middle, Last) 3. Time of Death 3:30 PM Lee B. Holt 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death Union Memorial Hospital Baltimore n/a 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1**√2**M 2□ F Months Deys Hours 264-26-9366 83 Yrs March 15, 1915 Ga Usual Residence of Decedent 10e Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore XX Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2525 Calverton Heights 21216 USA 12. Was Decedent Ever In U,S. Armed Forces? 1XDX'es 2□No 1943 If Yes, Give Year or Detes: 1945 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 ☐ Yes → No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3rd Grade Home Improvement Self-employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Albert Holt Katie Allen 19e. Informent's Name/Relationship (Type, Print) Wife 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Annie R. Holt 2525 Calverton Heights Ave. Baltimore, Md. 21216 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Rurial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Garrison Forest Veterans April 2 Owings Mills, Md. 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 nter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r hearf failure. List only one cause on each line. Approximate Intervel Between Onset end Death Pneumonia Immediete Cause (Final < 10 days disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertention 24b. Were eutopsy findings available prior to 24e. Wes en autopsy performed? completion of ceuse of deeth? Alzheimers Disease 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Naturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

AT 2438946-M17 March 29, 1998

State Registrar

PEIQING GA
31. Dete filed (Month, Day, Year) APR 01

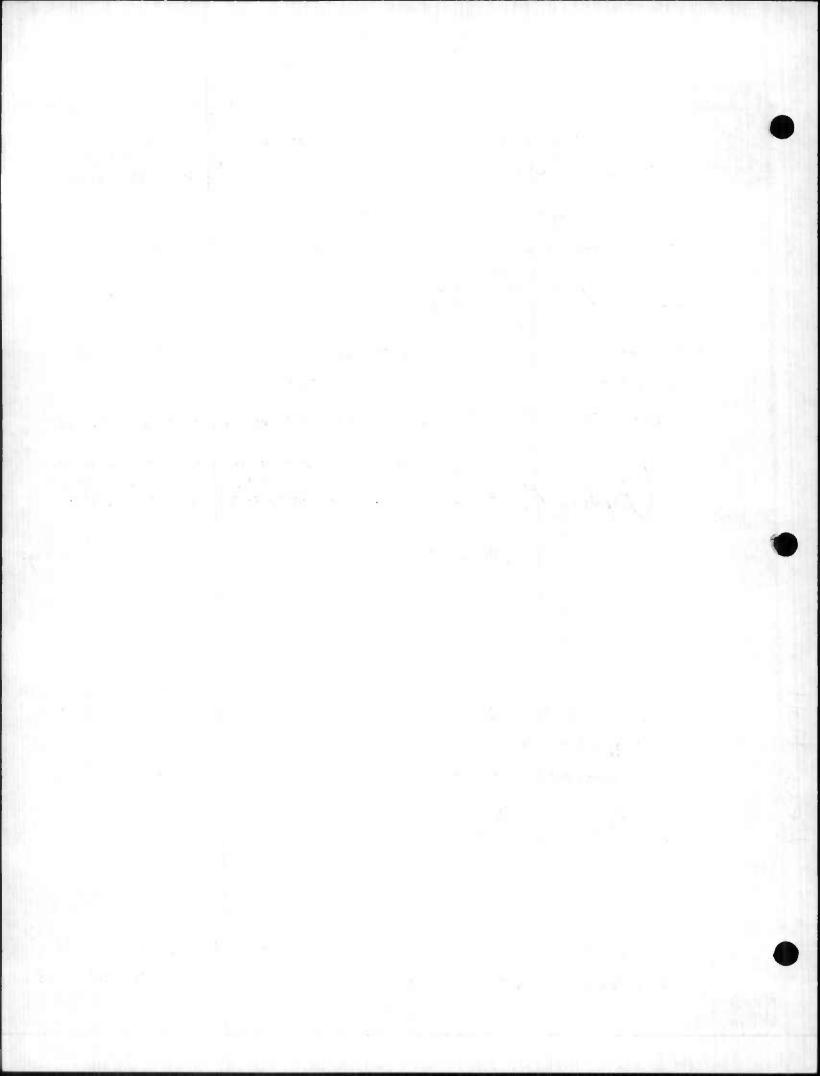
29a. Certifier

201 E. University Parkway, Maryland (Baltimore) 21218 M.D. 32. Register's Signature

Suna Davidson-Randata

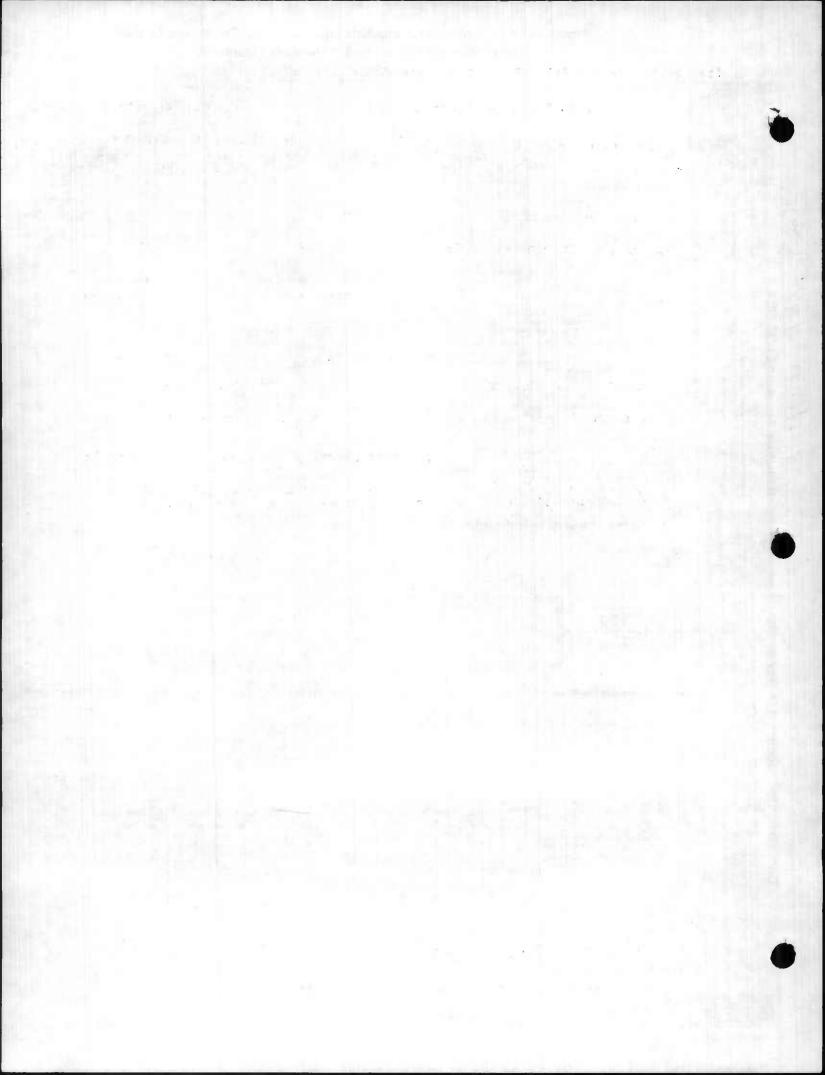
who completed ceuse of death (Item 23a) (Type, Print)

29b. Signeture and title of certifier



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

Lillian Elizabeth Hopkins Month 20 1998 124 4a Facility Name (If not institution, give street and number) An Prundel to Spital Glen Burnie Anne Arund 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Months Days Hours Min. Option 1999 124 9. Birthplece (Stete or Fo		I. Decedent's Name (First, Middle, Last)			ertificate of	D 0 0 1.7	2. Date of Deat	eg. No.	3. Time of I
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1	1	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13.	. Was Decedent of	Hispenic Orlgin? (S	Specify Yes or No- to Rican, etc.)		
Comparison of the property o			1 ☐ Yes 2 ☐ No If Yes, Give						
To Father's Name (First, Middle, Laset)				16a. Dec	edant's Usual Occi	upation	rkina	16b. Kind of Bu	usiness/Industry
18. Mother's Name (First, Middle, Late)				lifa.	DO NOT use retir	ed)			
Robert Gainus Butler 19a. Informant's Name/Relationship (Type, Print) Mr. Kennach Miller/son 19b. Mailing Address (Streat and Number or Pural Police Number, City or Town, State, Zip Code) Mr. Kennach Miller/son 1277 Delmont Road, Severn, Naryland 21144 20a. Method of Disposition 3 Removal from State 4 Constant on 5 Cheric (Specify) 21. Signaffice of Tuner(Psical Licenses) 22. Mane and Address of Facility Slack Funeral Florine, P.A. Ellicott City, MD 23. Same and Address of Facility Slack Funeral Florine, P.A. Ellicott City, Maryland 21043 25a. Fart Enter the disease, or dempirations that caused he death. Do not enter the mode of dying, auch as cardiac of respiratory arrest. Approximate Informatical Cause (Final disease) 25c. Mas case referred to medical exercisery 1 as y, leading to immediate 25c. Was case referred to medical exercisery 21 (Septiment Conditions contributing to death but not resulting in the underlying cause given in Pert I. 25c. Was case referred to medical exercisery 21 (Septiment Conditions) 22c. Mane of Death (Check only one) 1 (Yes 2 (No 3) (Probably 4) (India) 1 (Yes 2 (No 3) (Probably 4) (India) 22d. Was an autopoy 24d. Were autopoying to death of class of death	_	7		h	omemaker		me (First Middle I		
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** apolyN TURC /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Harford Memoria 7. Age (In yrs. lest birthday) AVEL GL If Under 24 Hrs. 8. Dete of Birth (Month, Day, 5. Sociel Security Number **Funeral** 6. Sex Birthplece (State or Foreign Country) Deys Hours 1□ M 25 F Months Min. -431(**Director** Usuel Residence of Decedent 10b. County 10c. City, Town or Location marked other than "natural", or items 23a or 28a-f show amatic event, the Mexical Examples maint be notified at 10d. Inside City Limits **Funeral Director** Maeyland 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 82 12. Was Decedent Ever In U.S. Armed Forcas? 1 Yes 2 No If Yes, Give / Yes, Gi 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. Marital Status Reca - American Indien, Bleck, White, etc, Pages 1 end 2 should be filed within 72 hours efter nent of Health end Mental Hygiene. 1 Never Married 2 Married Specify: White 1□ Yes 2 No Specify: Be Completed by 3 DWidowad 4 □ Divorced Year or Dates 16a. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 124RS Important: If item 27 is marked other any injury or other traumatic event, 000.6. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Reicher acob 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 20b. Place of Disposition (Name of cametery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State Department 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Chapel 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiec or raspiretory errest, shock, or heart failure. List only one cause on eech line. Approximete interval Between Onset end Death Physician Immediata Ceuse (Finel disease or condition resulting in daath) /Medical **Examiner** Due to (or ey a consequenca of): buriel-transit Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Ceuse (Diseesa or injury that initieted events resulting in deeth) Lest Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the ceuse of death? 1 Yas 2 No 3 Probably 4 Unknown Gastrointestinal Completed by 24b. Ware autopsy findings aveilable prior to completion of cause of daath? 24a. Was an autopsy performed? Bedridden Sta page 2 2 No 1 Yes 2 No funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yas 2☑No Certification: To this 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Affer 5 Pending investigation 1- Naturel 1 Yes 2 No 24 hours effer death. 2 Accident the 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide

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Registrar

Medical

29a. Cartifiar

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29b. Signature end title of cartifier

31. Dete filed (Month, Day, Yaar)

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30. Name and addrass of parson who complated causa of death (Item 23a) (Type, Print)

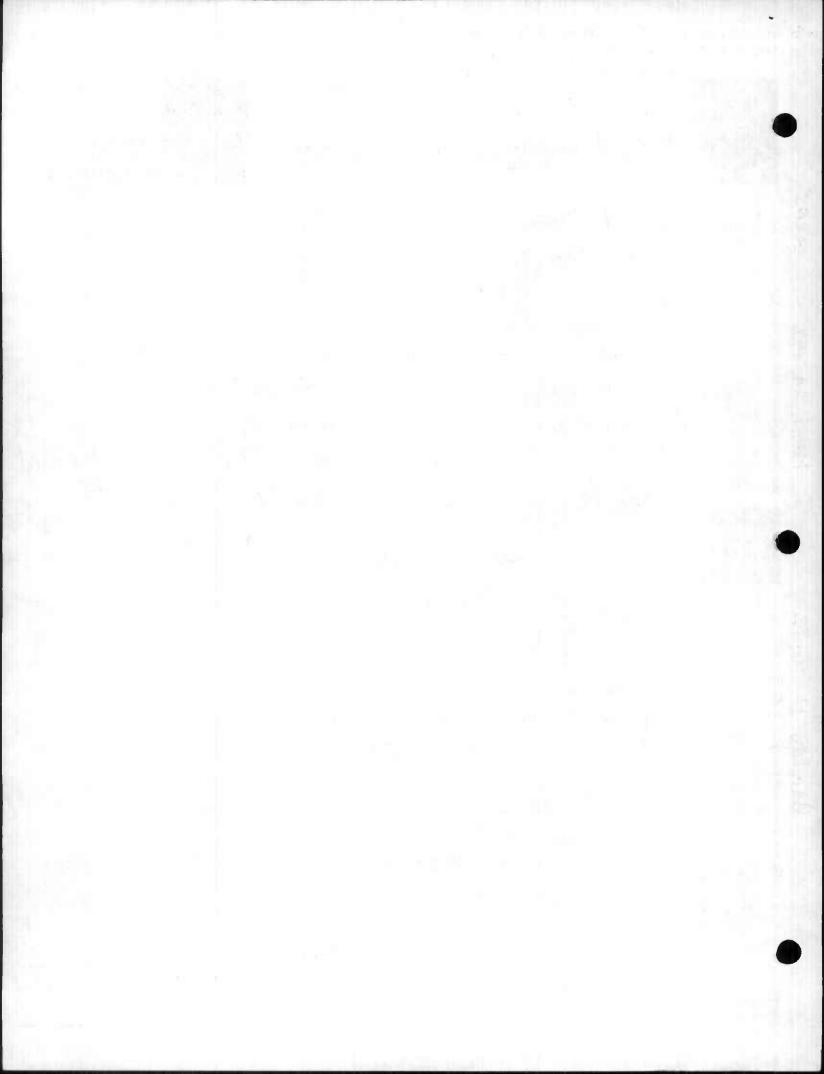
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t ☐ Cartifying Physician: To the bast of my knowladga, deeth occurred et the time, dete end placa, end due to the ceuse(s) end manner as ateted.

2 ☐ Madical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar steted. 29c. License number

29d. Date signad (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1 Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** MARCH 26, 1998 1:09 AM HODGES WALTER /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Baltimore Saint Joseph Medical Center Towson 8. Date of Birth (Month, Dey, Year) If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign , Country) 5. Sociel Security Number **Funeral** Months Deys Hours Min 1XM 2□ F 079-05-Yrs. 1916 New Director Usuel Residence of Decedent with the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Directo Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours eiter death with Department of Health and Mental Hygiene.
Important: If tham 27 is marked other than "natural; or itema 23a or any Injury or other traumatic evant, the Medical Experience mainton. 21234 272C Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [X yes 2 □ No lf yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Maritel Sfetus Bleck, White, etc. 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White py 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 124R8 18. Mother's Neme (First, Middle, Malden Surname) 17. Fether's Neme (First, Middle, Last) Be 19b. Mailing Address (Street end Number of Rurel Route Number, City or Town, Stele Zin Code) 19a. Informent's Neme/Rejetionship (Type, Prior) alter Hodges 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) March 20c. Locetick City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Cemeter 21. Signeture of Punerel Service Licensee 22. Name end Address of Fedlity vans 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** 2 DAYS /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) ACUTE MYOCARDIAL INFARCTION Examiner Due to (or es e consequence of) Examiner and I-transit thet the death certificete be axecuted Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) physicien ar Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 65 USB P signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1X Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE þ The law requires 24b. Were autopsy findings aveilable prior to completion of cause of deeth? been si 24a. Wes en eutopsy performed? Completed certificate hes b lirector, page 2 s 250 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) To Hospitei Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27 No ↑ Inpatient 2 ER/Outpatient 3 DOA After this funerel 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? Certification: Naturel 5 Pending Investigation 1 Yes 2 No death. ne Hospital or Attendi n 24 hours after death ne Funeral Director: A bletely filled in by the f 2 Accident 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 2 ORos 30263 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 21204 7620 YORK ROAD, MARYLAND TOWSON, FRANCIS KHOO. M. D. , Registrar's Signeture 31. Dete filed (Month, Dey, Year) State was Devidson-Randalle

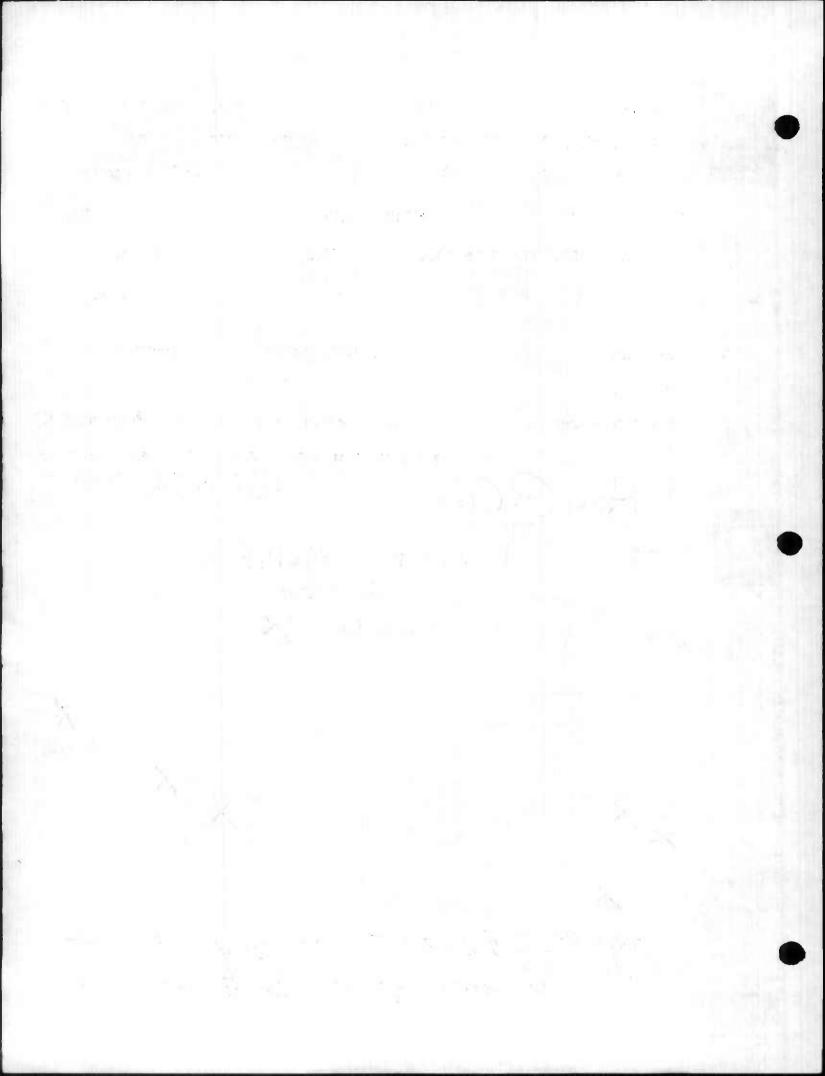
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				State of Ma	rylariu		tificate of	Death	cinairry	Reg. No.		0274
	Physici	an	Decedent's Name (First, Middle, Last CLIADLEC)	10	MEC			2. Data of De Month MAR	-	9 98	3. Time of Deeth
	/Medic Examir	ai	CHARLES 4e. Fecility Name (If not institution, give	street end number)	JU	NES		4b. City, Town, or Lo				3:17pm
	LAUIIII		1419 W. MULBERR	STREET	3rd F	Tr.		BALTIMORE			I/A	
	Funeral Director		5. Social Security Number 220-34-5886 Usual Rasidence of Decedent	7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Bir (Month, Da DEC.	T5°°1939	9. Birthp Cour MAR	place (State or Foreign http:// YLAND
	show		10e. Stete 10b. County		10c. City, 7						1	0d. Inside City Limits
	r 28a-f show	ector	MARYLAND N/A		В	BALTIN	MORE CIT	(Yas 2 No
	23a o	Funeral Director	10e. Street and Number 1419 W. MULBERRY					223			.A.	
	or ite	by	11. Marital Status 1 □ Never Married 2 ☒ X farried 3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:			Nas Decedent of I I Yes, specify Cub I □ Yes 2 ▼No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No Rican, etc.)		e - Americ k, White, BLA	
15-0	C 1 40	Completed	15. Decedent's Edu (Specify only highest gred	cation e <i>completed)</i>	1	6a. Deced	lent's Usual Occup kind of work done	pation during most of workind)	ng	16b. Kind of B	siness/In	dustry
212	Hyglane. ther than "	ошо	Elamantary/Secondary (0-12) 7th grade	College (1-4or 5+	-)		STRUCTIO			CONST	RUCT	ION
pu	0	Be	17. Father's Nama (First, Middle, Last)		-			18. Mother's Name		, Maiden Surnam	Θ)	1 72
ıryla	oz snouid be th end Menta 7 is markad traumatic ev	7	ROBERT JONES 19a. Informant's Name/Relationship (T)	ne Print)		19h Mailin	n Address /Stree	MARY MI		er City or Town	State Zir	Code
	Tale of Tale		Mary Hart/Mother	pe, r mit				son Street				
Baltimore,	egas ent of rt: If it y or o		20a. Mathod of Disposition XX Burlal 2 □ Cremation 3 □ F 4 □ Donetion 5 □ Othar (Specify)	lemoval from State	cem	etary, cren	sition (Nama of natory or other pla MEMORIAL		Data -1-98	20c. Location - BALTIMO		own, State MARYLAND
Balt	Department of important: If any Injury or once.		21. Signature of Funeral Service Licens	7.0	Pore	22	. Name and Addre	ess of FacilityWILL 1206		BROWN (RTH AVE		NITY F/H
	la de		23a. Part1. Enter the diseasa, or compostock, or heart failure. List only or	cations that caused the cause on each line	ha daath. I	Do not ente	er the mode of dyl	ng, such as cardiac o	r raspiratory a	rrest,	1	Approximate Interval Batween Onset and Death
	hysician /Medical		Immediate Causa (Final	NI	. 1.	-14	7	Malle	1		1	Onset and Death
E	Examiner		diseasa or condition resulting in death)	D.	oue to (or a	s a conseq	uance of):	Melli-	rus			
	nsit	Examiner		o	Hy	De	ters	191			i	
ć.	execution and viel-train		Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or Injury	Paci	fue to (of as	th conseq	uende aft:	1~				
68760,	meate be executed g physician and as tha buriel-transit	edical	Cause (Diseese or Injury that Initiated events rasulting in death) Last		ue to (or as	a consequ	uance of):					
9 x e	U 100			J								
. Box	ceam cen a attendin od for use	Physician/M	Part II. Other significant conditions cor	stributing to death but	not resultin	na in the ur	ndartving causa gi	ven in Part I	23b. Dld	tobacco use co	atribute to	the cause of death?
ords, P.O.	r requires mat the death certification in the signed by the attending should be deteched for use as	by Phys								Yes 2□No	3 🗆 Proi	11
		Completed							24a. Was	an autopsy ormed?	av.	ara autopsy findings ailable prior to mpletion of cause daath?
= 6	ata h page	Com							10	Yes 2 No	10	Yes 2□ No
of Vital	certific	Be C	25. Was case referred to medical exeminer?	lospital:			Otl	26. Place of Death				
o to	こ 年 声	n: To	1 ☐ Yes 2D No 27, Manner of Beath	1 ☐ Inpatien	28	Outpatien	t 3□ DOA DOA 28c. Inju	4 Li Nursing Hor		dence 6 □Oth how injury occur		v)
vision	eath. or: Aft the fur	2 Accident Investigation M 1 Yes 2 No										
5 5	after d Direct in by	entifi	4 Homicida determined	28e. Plece of Injur building, atc.	y - At home (Specify)	, farm, str	eet, factory, office	4	28f. Location (City or To	Street end Numb wn, State)	er or Rura	il Route Number,
- 1	to the frozential of attending Fri within 24 hours after death To the Funeral Directors After thi completely filled in by the funeral	edical C	29a. Cartifiar (Check only one) Certifying Physical Examination (Check only one)	ilcian: To the best of ner: On the basis of e and menner state	xamination	dga, daath and/or inv	occurred at tha ti estigation, in my	ma, data and place, a opinion, daath occurre	and due to tha ed at the tima,	cause(s) and ma date and place,	nnar as s	lated. the cause(s)
, f	To th comp	W	29b. Signature and title of centifier	Sunba	n	ME	29c, Licens	se number 50404	44	29d. Date signe	Month,	Day, Year)
	7		30. Name and address of person who co	mplated cause of dag	ath (Itam 23	Ba) (Type, I	Print) St	- R	HIL	ware	2	1223
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Handle	202	50	VI			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** King, Sr. Lymon 98 March 21, 17:32 '- /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1□M 2□F Days Hours Yrs 75 238-28-0896 Director 07-23-22 NC Usual Rasidenca of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at X Yes 2□ No Director Baltimore Md. NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 1919 Hope Street Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Haaith and Mantal Hygiene. Important: If Item 27 ie marked other than "natural", or ite 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 Navar Married Married altimore, Maryland 21215-0020 Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Co. Tractor Operator Unknown 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Mary Leary Joseph King 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 Kelox Road Baltimore, Maryland 21207 King, Jr. Lymon 20b. Place of Disposition (Name of cametery, crematory or other place, 20c. Location - City or Town, Stata 20a. Method of Disposition XX Burial 2 Cramation 3 Ramovai from State ò 03-27-98 Randallstown, Md. any injury King Mem. Pk. Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Addrass of Facility Baltimore, Maryland 21202 CUB WM.C. March FH 1101 E. North Avenue mean 23a. Part1. Entar the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested to the cause of the c Due to (or as a consequence of): requires that the death certificate be exec Box 68760. attending physician Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequence of) the 65 950 23b. Did tobacco use contributs to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to compiation of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3□ DOA 10 1 Inpatient this funeral 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? Certification: 28a. Dete of Injury (Month, Day Year) 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No e Hospital or Attendi n.24 hours after death e Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) end manner as stated. Medical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. To the F

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of contifier

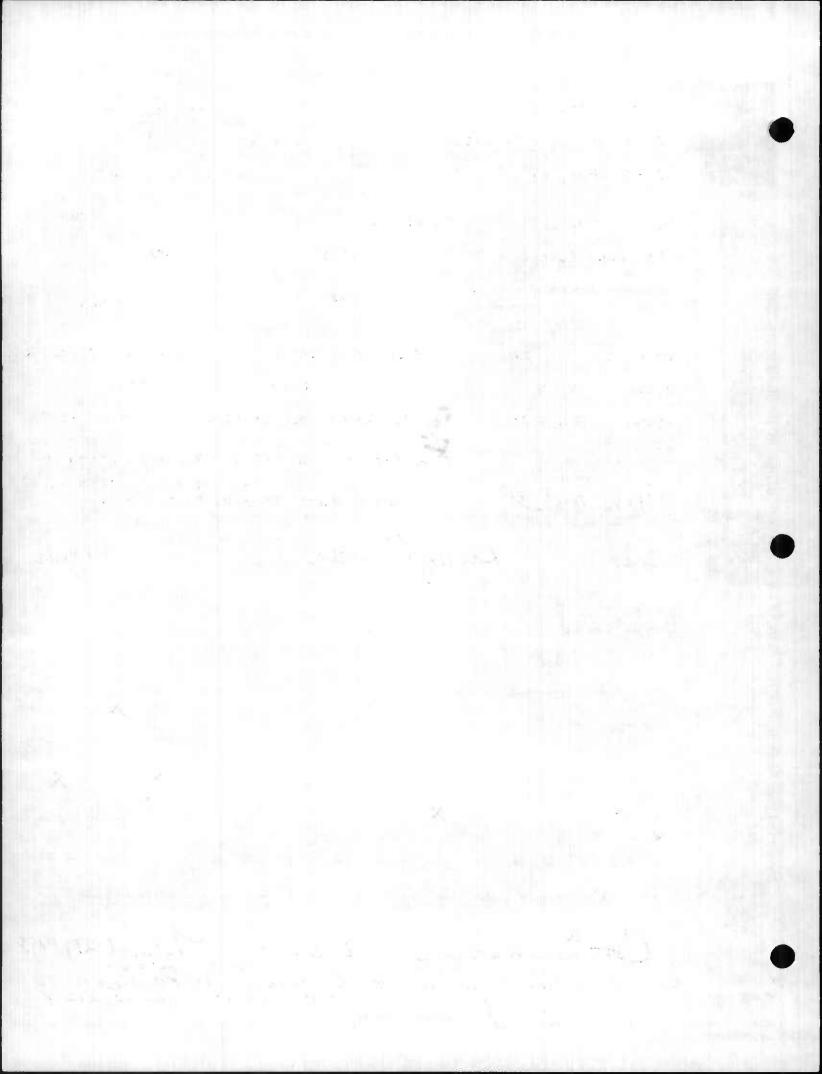
MEMORIAL

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

201 HOSPITAL 32. Registrar's Signature ina Davidson

E. UNIVERSITY Baltmore,

,0



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** KOHLWAY b. City, Town, or Location of Deeth WILLIAM 27 /Medical 4e. Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) MARIS HOSPICE ALUSTZ BALTIMORE 5. Social Security Number 6. Sex Birthpiece (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 4841 26 116 Yrs. APRIL 11, 1937 MARYLAND Director Usuei Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND BALTIMORE PIRRY HALL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23a APT. OVRT U.S.A 2FLANOERS 21336 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 € Yes 2 □ No If Yes, Give Year or Dates: \(\omega\) \(\omega\) \(\omega\) 1 Never Married 2™ Married 6 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced "natural", 3TTHW Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within ont of Haalth end Mental Hygiena. Int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 127RS 1YR. MANAGER- TINT DENTER DELL ATLANTIC 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) WILLIAM H. KOHLWAY, ADDA OTTEY 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PERRY HALL 20c. Location - City or Town, State Department of Haalth Important: If Itam 27 2 FLANDERS LOURT APT. ROSS M. KOHLWAX 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete MARCHSI 1 Buriel 2 ☐ Cremetion 3 ☐ Removal rom State 4 ☐ Donation 5 ☐ Other (Specify) PARKYIN MARVIAGO ARKWOOD 1998 22. Name end Address of Fecility F MIN 21. Soneture of Funeral Service Licensie 10 RiEs 31234 8800 HARFORD ROD ARYLAND 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervai Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last pue Due to (or es e consequence of) attanding physician for use as the burie Box 68760 Physician/Medicai the Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 28 No 3 Probably 4 ☐ Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? ceta hes ; 1 Yes 28 No 1 ☐ Yes 2 ☐ No certificeta of Vital ospital or Attending Physician: hours aftar death. uneral Director: After this certifice ity filled in by the funeral director, I 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPics 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Neturei 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours afta To the Funeral Dir ↑ Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 ■ Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end une of certifier 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 16 Bay 6/95

State

Registrar

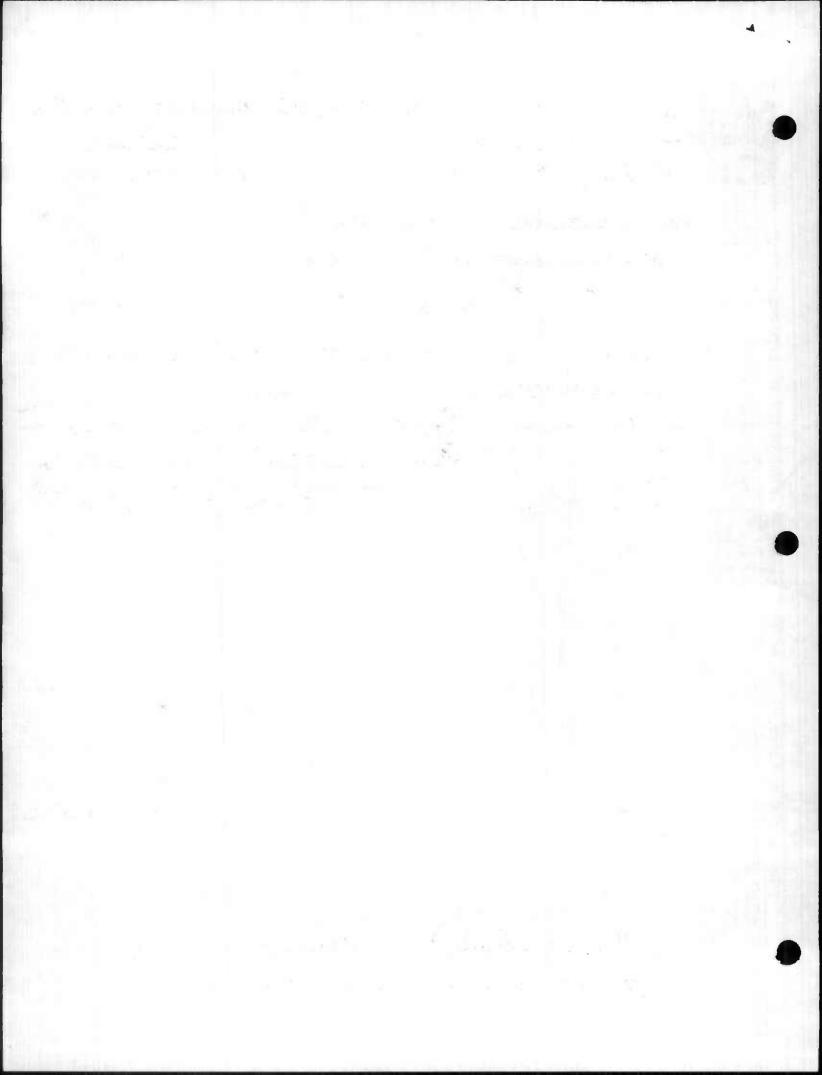
DR. PENELOPE EDWARDS

APR 01 1998

32. Registrer's Signeture

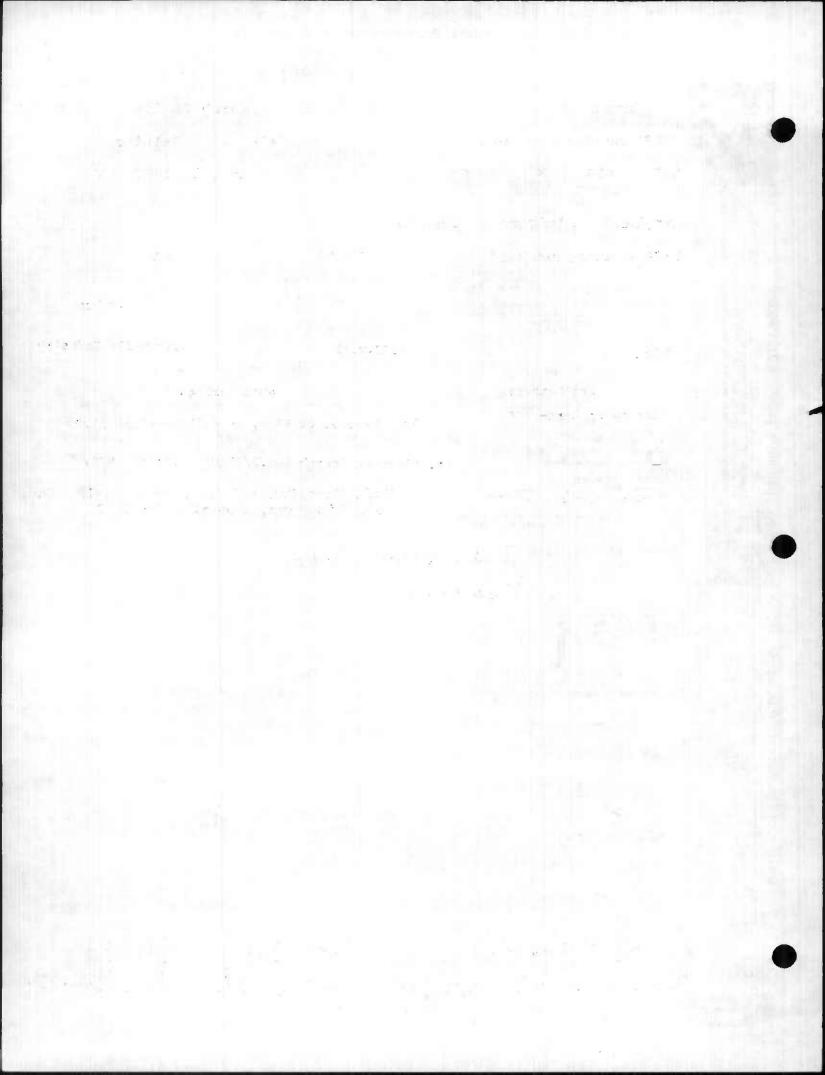
relia Davidson-Randelle

31. Dete filed (Month, Dey, Year)



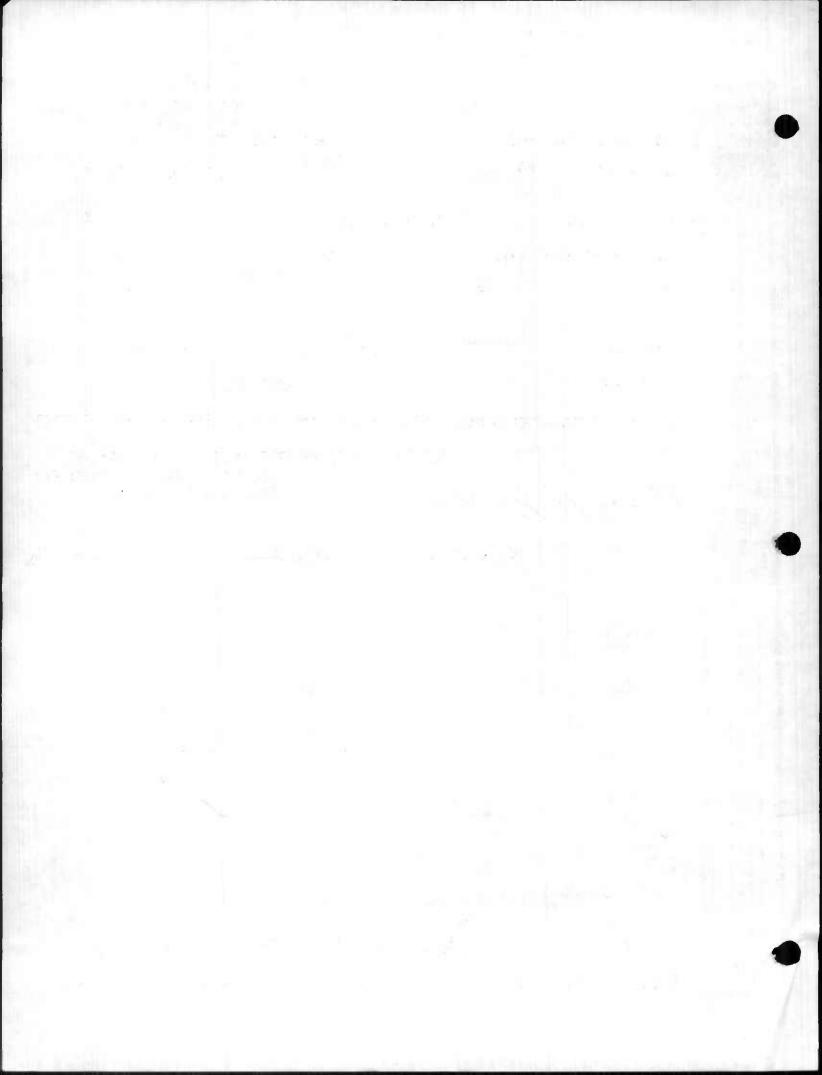
State of Maryland / Department of Health and Mental Hygiene 98 10277

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kaminer	40	Facility Neme (If not institution	on, give	street and r	number)					4b. City, To	wn, or Lo	cation of Deat	h 4c. (County o	of Death		
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Funeral Director	7	336 Manches	ter	Roa	đ			2	21222	2			US	A			
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o Be		Tra	Tam	bert							Cudi	a Amba	~~~				
5	19	a. Intermant's Name/Raiation					19h Mailir	Sudie Arbo Mailing Addrass (Street and Number or Rural Routa Numb						r Town. S	Stata. Zip (Code)	
	"	Sandra Lambe	ert-	WIFE							Road, Dundalk Maryland 21222						
	204	e. Mathod of Disposition				20b. Plac				cer K	Jau,	Date					
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		4 □ Donation 5 □ Other (5	Specify))		Mt.	Plea	sant	Chu:	rch Ce	em. 3/	/31/98	Har	riso	nburg	J, V	A
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				State of Ivia		ertificate of	Health and M Death	-	Glerie 9 8 Reg. No.		0278
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ADA B		VIS			2. Date of De Month MAR	_	Year .998	3. Time of Death
	Examir		4a. Facility Neme (If not institution, give				4b. City, Town, or Lo	ocation of Death			ulikilowii
			5917 WESTERN PARI				BALTIMORE		N/		
	Funeral Director		5. Social Security Number 6. Se 212-30-4643	M XXF 7. Age	(In yrs. last birthda) 65 Yrs.	Months Days		8. Dete of Bird (Month, Da JUL 14	y, Year) 1932	9. Birthp Coun GEOF	lace (State or Foreign (n) KGIA
	show		10a. Stete 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits
	death with the Maryland ms 23s or 28s-1 show	tor	MARYLAND N/A		BALTIM	ORE CITY					XIX Yes 2□ No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23a		5917 WESTERN PARK	DRIVE		2120	09		U.S	.A.	
020	urs after ai', or ite	by Funeral	11. Marital Status 1 (X) Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N if Yes, Give Yeer or Dates:		Was Decedent of if Yes, specify Cub 1 ☐ Yes 2 ☒ ✗o	Hispanic Origin? (Special, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)	Bla	e - Americ ck, White, v: BLA	etc.
21215-0020	c .	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) IIth grade	cetion e com <i>pleted)</i> College (1-4or 5-	+}		pation a during most of working ad)	ing	16b. Kind of B		
12	filed withi Hygiena. other than	Co	17. Father's Name (First, Middle, Last)		DI	ETARY	40 Mathada Nama	Cina Adidate	NURSIN		ITER
Maryland	2 should be filed and Mental Hygi Is marked other surmatic event, I	Be c	CLEVE LEWIS CO						Maiden Suman	10)	
2	should nd Me mark imatic	ĭ	19a. informant's Neme/Relationship (Ty	pe. Print)	19b. Mai	ing Address (Stree	and Number or Rure	LEWIS	er City or Town	State 7in	Code)
	alth ar 127 is or trau		SHARRON FAULKNER-		F04 =		Park Driv				
Baltimore,	Page ent of ry or		20a. Method of Disposition 1) eurlal 2 Cremetion 3 F 4 Donation 5 Other (Specify)	1	20b. Plece of Disp cemetery, cre	osition (Name of ematory or other pla NATIONAL	CEMETERY	Date 3/31	20c. Location		
Balti	permit. Page Department of Important: If any injury or once.		21. Signatura of Funeral Service License	"A			ess of Fecility WIL	LIAM C.		COMMU	
		-	22a Part. Erief the disease, or tompi shook, or heart fallure. List only or	that caused ause on each iin	the death. Do not er	iter the mode of dy					Approximate intervei Between
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)		AST Due to (or as a conse		ICER	_		1	6 Months
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	In/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	:C	Due to (or es a conse						
	the atte	Physician/M	Pert ii. Other significant conditions con	tributing to death bu	t not resulting In the	underlying ceuse g	iven in Part i.	23b. Did 1	tobacco use co	ntribute to	the cause of death?
, P.O	es that the de igned by the a be detached t	by Ph						10	Yes 2 No	3 Prot	ebly 4 Unknown
Records,	aw requires seen so 2 should	Completed b						24e. Was perfo	en autopsy med?	ava	re eutopsy findings illable prior to appletion of ceuse death?
	The ata h	Con						101	res 2000	10	Yes 2000
of Vital	Physician: The	Be	25. Was case referred to medical examiner?	ospitei;		0	26. Place of Death	(Check only o	MAS)		
	Q 60 X	5	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	1 Linpatier		nt 3L DOA	her: 4 Nursing Hor		dence 6 Oth	er (Specif)	')
on	Attending F or death. ector: After by the funer	itlon	1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day)	Year) injury	Wo	ork?]Yes 2□No	200. Describe i	low injury occur	160	
Division	i or Attendi i after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end man and manner stated.								nner as st and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature end title of certifier	hul	dru.	29c. Licen	se number 29071		29d. Date signe	d (Month, I	Day, Year)
	(3)0)		30. Name and address of person who co	mpleted ceuse of de	ath (item 23a) (Type	Print) TAW	57 #305	-BAL	TIMO	Q15	21201
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 1998	32. Registra	r's Signature Davidson-Ron						1

DHMH 16 Rev 6/95



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Ì	Physicia		Items: 23 part I, I 1. Decedent's Name (First, Midd))	Wayne	<u> </u>			Loque, J		2. Dete of Deet Month		Year	3. Time	of Death	
	/Medic Examin	al	4e Fecility Neme (If not institution	n, give	street end nun	nber)		_		4b. City, Town	, or Loca	MARCH atlon of Death	28, 19 4c. County	98 of Deeth	7:55	A.M.	
₹			1538 INGLESIDE	AVI	Ξ					WOODL	AWN			MORE			
	Funeral Director		5. Sociel Security Number 216-58-2024	6. Se	X DMM 2□F	7. Age (In yrs. 46	lest birtho	Mont	nder 1 Yea ths Day		Hrs. 8	B. Date of Birth (Month, Dey, May 15	Year) ,1951	Coui	ntry)		
	Aaryland I show	ō	Usuel Residence of Decedent 10e. State 10b. County Maryland		timore	10c. Cit	y, Town o	r Location		Cat	ons	ville					
	the A	Director	10e. Street and Number					10f.	Zip Code			1	0g. Citizen of	Whet Cou	ntry?		
	3a or	5	1538 Inglesi	ide	Avenue					2120	07						
020	within 72 hours after death with the Maryland ena. than "naturel", or items 23s or 28s-f show he Mexical Exercises must be notified at	by Funeral	11. Maritel Stetus 1 Never Merried 2 Mer 3 Widowed 4 Noivorced	Armed Forces? Never Merried 2 Merried Widowed 4 Dovorced Merried Yes, Give Yeer or Detes: 15. Decedent's Education (Specify only highest grade completed)				13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.)					Ble	ck, White,	etc.		
21215-0020	d 2 should be filed within 72 hours aft in and Mental Hygiena. 7 is marked other than "natural", or traumatic event, in Medical Exercitations.	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12 Years		l work don Tuse retii	upetion e during most of red)	f working	7			dustry						
Maryland	S should be filed withing and Mental Hygiena. Is marked other than aumatic event, the Management of th	To Be C										First, Middle, I rfield	Meiden Suman	ne)			
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Baltimore,	20 5		20e. Method of Disposition **EBuriel 2 Cremetion 4 Donation 5 Other (S	3 □F Specify)	Removel from S	State	emetery,	isposition of cremetory awn C	or other p		31/1		ete 20c. Location - City or Town, Stete				
Balt	permit. Pag Department Important: If any Injury o		21. Signeture of Furleral Service	1	1/	II)		79	22 W	ise Ave.	. Du	ndalk.	Marvla				
			23a. Parti Enter the diseese, o shock, or heart feilure. List	compl only o	lications thet d ne ceuse on e	used the deet	h. Do not	enter the	mode of d	ying, such as ca	rdiac or	respiretory arr	est,		Intervel 6	Between	
1	Physician . /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	1	e. MYOCAR										Onset ar	nd Deeth	
	P .=	amlner				Due to (c	or es e cor	nsequence	of):					3. Time of Dea y Year 8, 1998 7.55A.M ALTIMORE 9. Birthplece (Stete or For Country) New York 10d. Inside City Lin 1 Yes 20 itzen of Whet Country? ited States 14. Rece - American Indien, Bleck, White, etc. Specify: White ind of Business/Industry N/A or Town, Stete, Zip Code) 2, MD 21222 ocation - City or Town, Stete altimore, Marylar Dundalk, Inc. cyland 21222 Approximate Intervel Between Conset and Deet			
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x 68760,	phys the						r es e con	sequence	of):								
). Box	attar for u	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give							given in Pert I.		23b. Dld to	obacco use co	ontribute 1	o the cau	se of death?		
, P.O	thet the	RESOLVING PNEUMONIA									1 □ Y	es 2 No	3 Pro	bably 4	Unknow		
Records,	ecords, aw requires t as been sign 2 should be		SCHIZOPHRENIA									24e. Wes e perfor		an Ci	ere eutopo vellable pri ompletion of death?		
	The page	EoS										1)X Y	es 2 No	1.	Yes 2	2□ No	
Vital		Be	25. Wes cese referred to medical								Death	(Check only or	10)				
of	Phys rathis	1: To	XXYes 2□ No 27. Menner of Deeth				ER/Outpo		DOA			e 5 Reside			fy)		
Division	ing After fune	ertification:	1 X Naturel 5 ☐ Pendi	igetion		of Injury h, Day Year)	Inju	Iry M		Yes 2 No					al Route A	lumber	
Divi	or Attend after death Director: /	ertit	4 Homicide determ		259. Piece buildir	of Injury - At he ng, etc. (Specif	y)	ı, sır e et, ta	скогу, опіс	e e	20	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					

within 24 hours after death.

To the Funeral Director: After this certificate has

To the Hospital or Attending Physician: The law require

completely filled in by the funeral director, page 2 should b Medical Certification: To |

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year) 29c. License number

29b. Signeture end title of certifier

O.C.M.E.

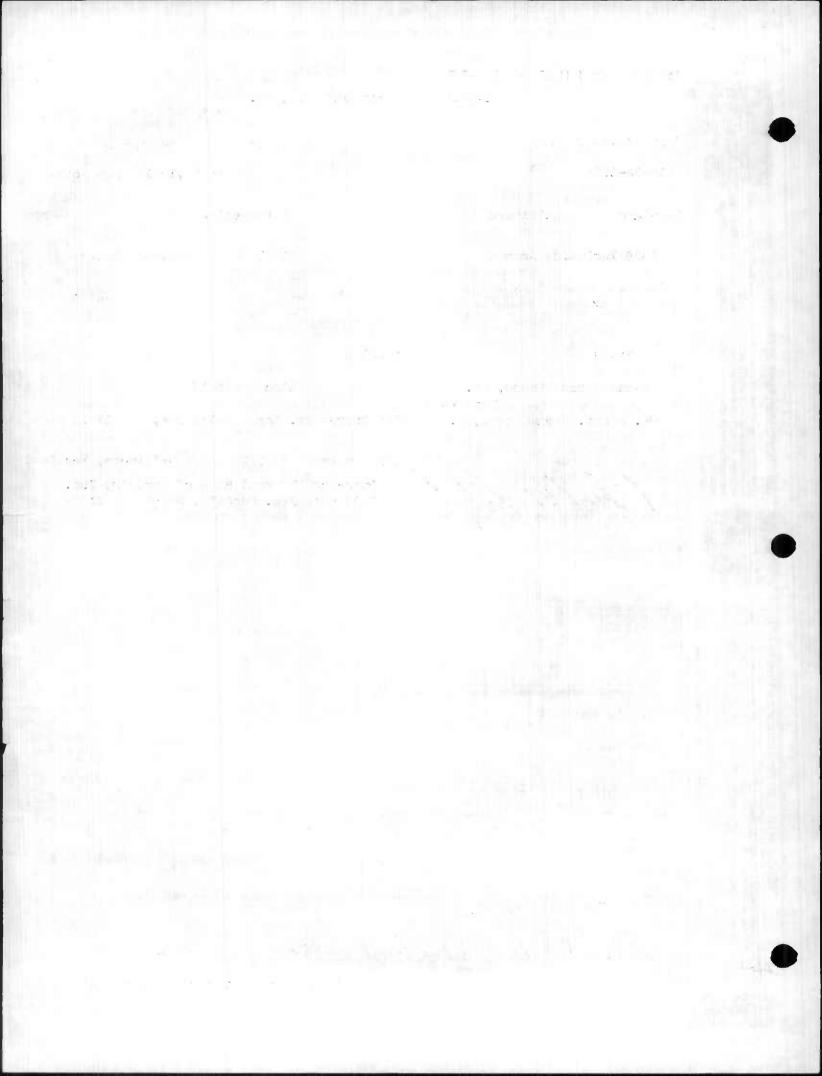
MARCH 28,1998

30. Name end eddress of person who completed cause of death (Item 23a) Plype, Print)

Strphen S.
31. Date filed (Month, Dey, Year)
APR 0 1. 1998 adent 2 111 Penn Street, Baltimore, Maryland 21201

State Registrar

82 Registrar's Signeture Why Davidson-Randalls



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death **Physician** Herbert Lowery March 27, 1998

4b. City, Town, or Location of Death 4c. County of Death 12:00p.m. /Medical 4a Facility Name (If not Institution, give street and number) Examiner 1942 W. Lanvale Street n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Dale of Birth (Month, Day, Year) **Funeral** Days Hours 10M 20 F 213-09-0338 83 Yrs. **Director** Oct. 29, 1914 SC Usual Residence of Decedent deeth with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Md. n/a Baltimore 1 XXes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1942 W. Lanvale Street 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 6th grade General Rigger 18. Mother's Nama (First, Middle, Maiden Sumama) WN Known 17. Fathar's Name (First, Middle, Last) LINK nown permit. Pages 1 and 2 should be filt.
Depertment of Health end Mental th, important: if Nem Z7 is marked oth any liqury or other traumatic even page. 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 1942 W. Lanvale Street Baltimore, Md. 21217 Mary E. Lowery 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) April 1 Arbutus Memorial Park Baltimore, Md. 22. Nama and Address of Facility 21. Signature of Funaral Service Licent Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Severe Ischemic Cardiomyopathy UNKHOWN Examiner Due to (or es a consequence of): 5 days Physician/Medical Examiner Myocardial Infarction signed by the attending physician and d be datached for use es the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants Due to (or as a consequence of): Dua to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contributs to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cerebral vascular accident by 24b. Were autopsy findings available prior to completion of cause of deeth? should t 24a. Was an autopsy performed? Completed chronic renal insufficiency cartificate has 1 Yes 2 No aspiration 1 Yes 2 No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 After this funeral 27. Menger of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending Investigation ours eftar death. 1 Tyes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital
within 24 hours e
To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number Am you MD 120051807 4/1/98 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Gloria Yim, MD 419 W. RedWood St., Baltimore, MD 21201 32. Registra s Rignara - Rondard 31. Dete filed (Month, Day, Year) State APR 0 1 1998

Registrar

Baltimore,

Division of Vital Records, P.O. Box 68760.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1 Decedent's Nama (First Middle, Last) 2. Data of Deeth **Physician** 74 Benjamin Leitch John 12:00 PM March 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Nama (If not institution, giva street end number) Examiner PARKYIlle Baltimore 3042 Moreland AYE If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12M 2□ F 12 9195 76 Yrs February 13 MArylAnd **Director** Usual Rasidence of Decedant permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hypiene. Important: If item 27 is marked other than "naturef", or items 23a or 28a-4 show eny injury or other treumatic event, in Medical Examination must be notified at ence. 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Moreland SVA USA 3042 Funerai 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14 Race - American Indian Black, White, etc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Hhite Specify: þ 3 ☐ Widowad 4 ☐ Divorced MM II Completed 16b. Kind of Businass/Industry 15. Dacedent's Education (Specify only highast grada complated) 18a, Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) Elamantery/Secondary (0-12) Collaga (1-4or 5+) Pennsylvania Rail Road Inspector 10 18. Mothar's Nama (First, Middla, Maldan Sumeme) 17. Fathar's Nama (First, Middla, Last) Leitch B. John Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) Leitch Moreland Ave MARY P. Parkville 3042 MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata Data MATCH 1 ☐ Burial 2 Ø Cramation 3 ☐ Ramoval from Stata Garrison Forest Veterans Cemetery 4 □ Donation 5 □ Othar (Specify) 30 1998 GATTISON, 22. Nema end Addrass of Facility 21. Signatura of Funaral Sarvice Licansee Funeral Chapel EVAMS 8800 Harford RI. Baltimore MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset end Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) year cancer Examiner Due to of es e consequenca of): Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Ceusa (Diseasa or Injury that initiated evants rasulting in daath) Last Due to (or es a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Dua to (or as a consaguanca of) as 980 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? Completed completion of causa of death? irector, page 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No al or Attending Physician: The safter death. 25. Was cese referred to medical examiner? Be 28. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 AesIdence 8 Othar (Specify) 1 ☐ Yas 2 ☑ No 10 28a. Dete of injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) in 24 hou. 4 Homicida 29a. Cartifian 1 Cartifying Physician: To the best of my knowladga, death occurred at tha tima, data and place, and dua to the ceuse(s) and mannar as steted. To the Hosp within 24 ho To the Fune completely fi Medicai (Check only 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 290. Signature and His of certifier 29d. Data signad (Month, Day, Year) 29c. License number 36131 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Brave Ste. 203 G.M 7400 Osler Dr. MD. Michael lowson ,

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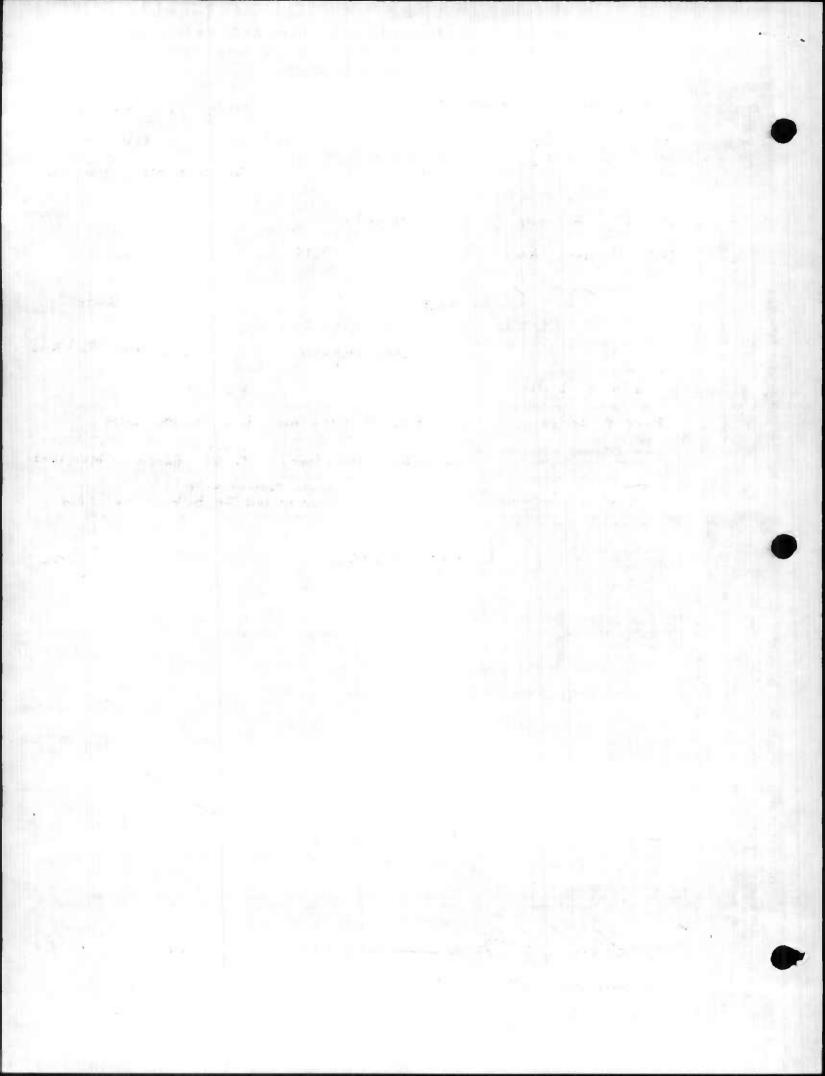
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32 Registrar's Signature

ia Davidson Randalle



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** LORELLO MINNIE Mar 1040 AM 16 1998 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL HOSPITAL COUNTY COLUMBIA HOWARD HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Dave Hours Min. (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2日F Director Yrs July 21,1903 045-12-0206 Connecticutt Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at Maryland Howard County Columbia 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5635 Harpers Farm Road 21044 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 5 Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after ond Mental Hygiena.

marked other than "natural", or iter 1 Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: p 3% Nidowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupetion 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker at home permit. Peges 1 end 2 should be file Department of Health end Mental Hy Important: If flem 27 is marked other any injury or other traumatic swent price. 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Frederick Wilson Minnie Lydon 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5635 Harpers Farm Road, Columbia, ND 21044 19a. Informent's Name/Relationship (Type, Print)
Mr. Charles Lorello, Jr./son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Depria 2 Cremation 3 Removal from State St. Patrick Cemetery Mystic, CT 5 ☐ Other (Specify) 21. Sign 22. Name and Address of Facility
Slack Funeral Home, P.A. Funeral Service Licenses M00535 Ellicott City, Maryland 21043 int / Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final PERITONITIS disease or condition resulting in death) **Examiner** BOWEL PERFORATION Examiner physician end the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Lest PSEUDO UBSTRUCTION MEGACOLUN AND Physician/Medical Due to (or as e consequence of): DEMENTIA SENILE ō Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ cate has been sig ; page 2 should b 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Ves 2 □ No 1 Yes 2 TNo certificate Hospital or Attending Physician: 24 hours aftar death.
Funeral Director: After this certificatath filled in by the funeral director; Be 25. Was case referred to medicel 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigetion Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Complataly filled edicai Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d, Date signed (Month, Dev. Year) D41836 1998 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Balt 4713 Leeds ve

State Registrar

31. Date filed (Month, Dev. Year) 01 1998 32 Registrar's Signature gria Davidson-Randelle

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Baltimore, Maryland 21215-0020

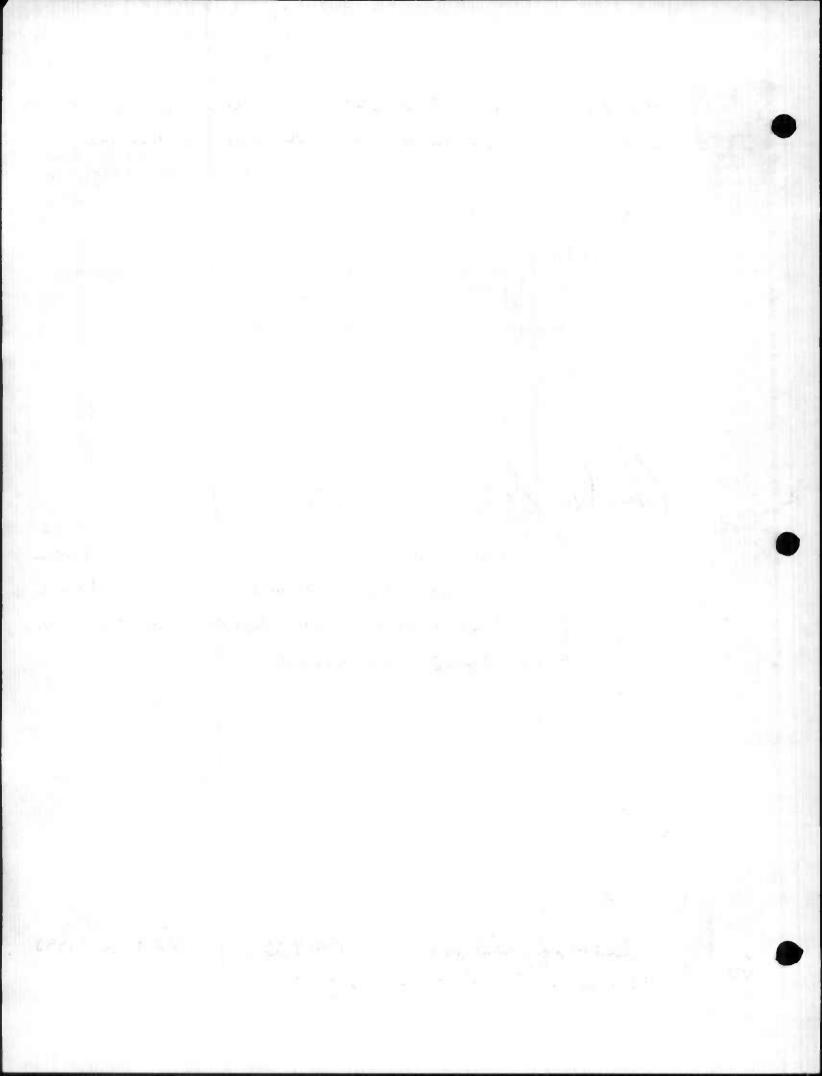
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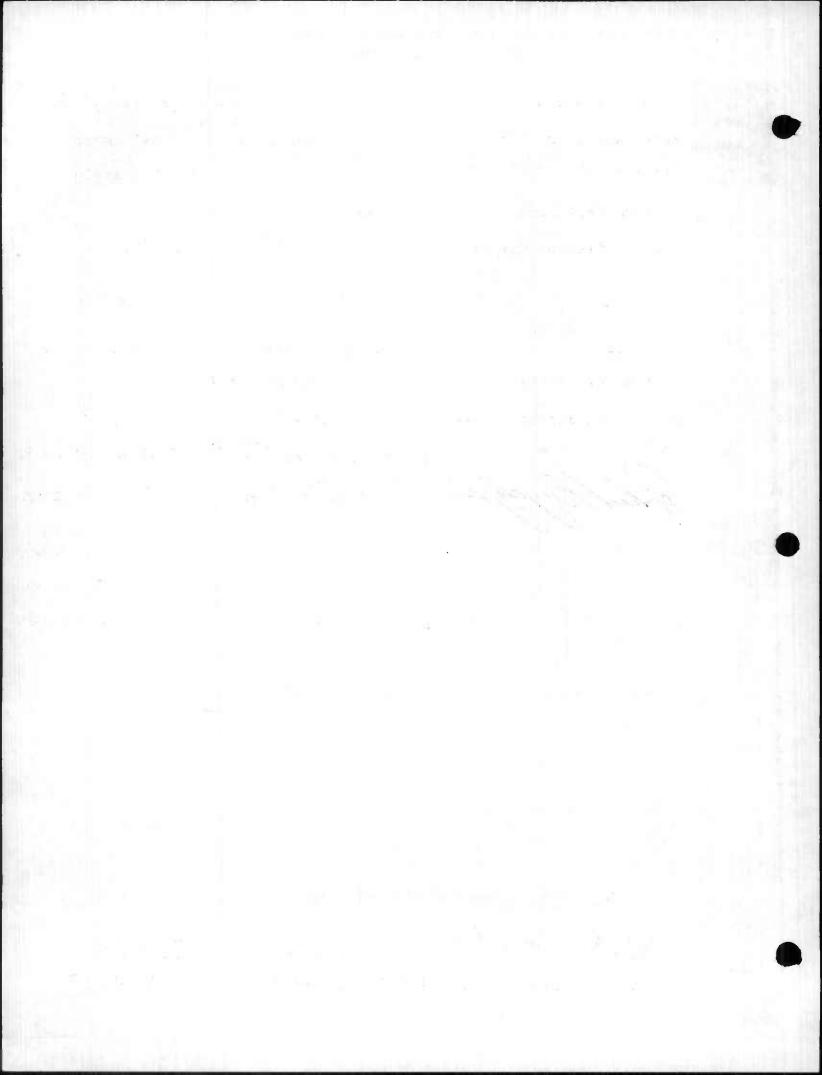
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State of Maryland / Department of Health and Mental Hygiene

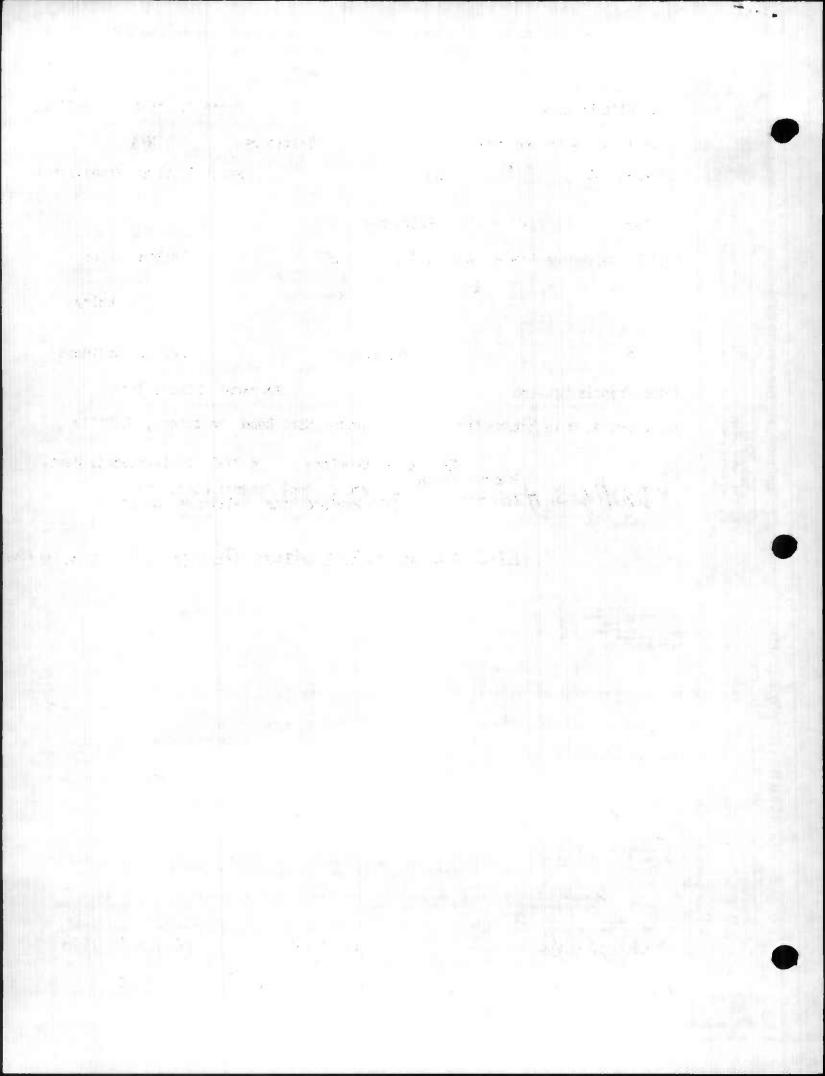
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Emma Katherine Month Lupinek 5:30 pm 1998 March /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2211 Hamiltowne Circle Rosedale Baltimore H Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Country)
Oct. 14, 1923 Maryland 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Funerai 217-12-8890 1□M 205F 74 Yrs. Director Usual Rasidance of Decedant Maryland 10a. Stata 10b. County 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or leams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Insida City Limits Maryland Baltimore Rosedale Director 1 Yas 2 No 2 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2211 Hamiltowne Circle 21237 U.S.A. Funeral death 11. Maritai Status 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Biack, Whita, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) filed within 72 hours after 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Administrative Asst. State Government 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be nent of Health and Mental William H. Maddox Charlotte Janne 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) nt of Health a : If ham 27 is r or other tra Joyce Lynn Jacobs (Daughter) 2209 Corsica Road Essex, Md. 21221 3/3 Pare 1998 Oc. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Baltimore Co., Md. Gardens Of Faith Cemetery 4 Donation 5 Other (Specify) Funguet Bervice Econolie Bruzdziński facili uneral Home P.A. Essex, Md 21221 1407 Old Eastern Avenue that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batw Onset and Death **Physician** /Medical Immediata Causa (Final ERTENSION INO YEARS disaasa or conditior rasulting in daath) Examiner Dua to (or as a consequence of):

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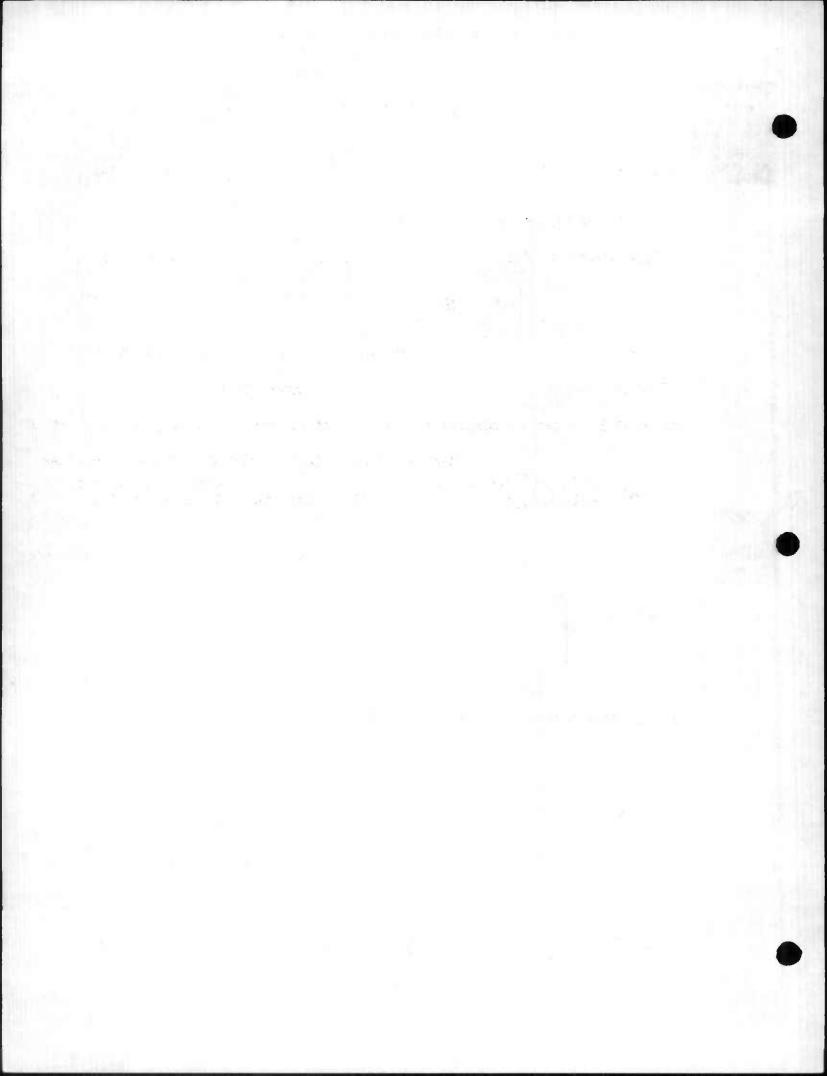
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	Physic	ian	Decedent's Neme (First, Middle, La					_	2. Dete of De Month		Year	3. Tima of Death
	/Medi		MILTON 4e. Fecility Name (If not institution, giv COOD SAMA		17	ORG	-AN		MARC	4 291		857 pm
	Exami	ner	4e. Fecility Name (If not institution, giv	e street end number)	11-56	1702	4	b. City, Towr	n, or Location of Deat	h 4c. County		
			5. Social Security Number 6. S	RITAN	140 >1	////C	or 1 Voor	>74 /	1790RR		N/A	
	Funeral Director			X M 2□F	a (In yrs. lest birth	rs. Month:	Deys	Hours	Hrs. 8. Dete of Bir (Month, De 12/22)	ny, Year)	9. Birthple c	e (State or Foreign
			Usual Residence of Decedant		01				12/22/	1910	Mary	land
	the Maryland 28a-f show notified at		10a. Stete 10b. County		10c. City, Town	or Location					10d.	Inside City Limits
	a Na September	cto	Maryland Baltim	ore Co.	Parkv	ille						1 ☐ Yes 2 No
	ith with the Marylar 23s or 28s-f show ust be notified at	Dire	10e. Street end Number			10f. Z	ip Code			10g. Citizen of	Whet Country	?
	23a MEE 3	Funeral Director	2524 Canterbur	y Road			2123				d Stat	es
	ar death w litems 23a Der must	nue	11. Marital Status	12. Was Decedent I Armed Forcas?		13. Was Dec If Yas, sp	edent of Hi ecify Cuba	ispenic Origir n, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac Ble	ce - Amarican ck, White, etc	
20	1 6	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yas 2 □ N If Yes, Give Yaer or Dates;		1□ Yes	2 🛭 No	Specify:		Specif	v: Wh	ite
8	natural.	P	15. Decedent's Ed			Decedent's Us	uel Occupi	ation		16b. Kind of B		
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2	d with	mo.	6	College (1-401 5		Unknowr)			Manu	factur	ing
pu	tal Hyger tile of the event,	Be	17. Fether's Neme (First, Middle, Last)					18. Mother's	Name (First, Middle,	Meiden Sumen	na)	
yla		To	Charles Morgan					Ann	a Smith			
Maryland 21215-0020	20年		19e. Informent's Neme/Ralationship (,				and Number	or Rural Route Numb	er, City or Town,	State, Zip Co	ode)
	s 1 and of Health Hern 27 other b		Mrs. Dana E. Morg	an / Grandd		904-D		sica L	1			d 21014
10			20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removel from State		, crametory or	other plec		Dete	20c. Location		
Baltimore	artmen ortant: injury 8.		4 ☐ Donetion 5 ☐ Other (Specify		Garden				4/3/1998	Baltimo	ore, Ma	ryland
Bal	Department Copartment of Important: If any Injury or ange.		21. Signeture of Funeral Service Licen	Michael E	. Canapp			s of Facility		rd J. R		
			Michel	ay!					oad Balti		arylan	d 21214
			23a. Pert1. Enter the diseese, or companies shock, or heart feilure. List only	one ceuse on eech lin	the deeth. Do no e.	ot enter the mo	de of dyin	g, such es ce	rdiac or respiretory e	rrest,	In	oproximete tervel Between nset end Death
	Physician / /Medical		Immediete Ceuse (Finel	~					10	1 - 5		
	Examiner		diseesa or condition resulting in deeth)	· ACVT				MAL	INFA	RCIIC	N.	15 HRS
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	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the bunal-transit	Examiner	Sequentially list conditions.	b	Due to (or as e co	onsequence of):				1	
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	the de	ysic	Pert II. Other significant conditions co	ontributing to death bu	t not resulting in	the underlying	ceuse give	en in Pert I.	23b. Dld	tobacco use co	ntribute to th	e cause of death?
P.0	that the ed by detail	F.	PUL MONA	RY	EDE	MA			10	Yes 2□ No	3 Probab	dy 4 Unknown
Records,	w requires that been signed be should be detailed.								24e. Wes	en eutopsy	24b. Were	eutopsy findings
00	> 00	Completed				_			perfo	rmed?	evaile comp of dee	eutopsy findings ble prior to letion of cause
Re	The law ate has b page 2 sl	шс							10	Yes 2000		es 2 No
tal	ician: The lav certificate has rector, page 2	BeC	25. Wes case referred to medical					26 Place of	f Deeth (Check only o		107	62 20 140
of Vital		ToB	exeminer? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2 ER/Out	petient 3 0	Othe	NP:	ing Home 5 ☐ Rasi		ar (Specify)	
0	F 5 8		27. Manner of Daath	28e. Dete of Injur (Month, Day			28c. Injury Work			how injury occur		
Division	ath. r: Aft	Certification:	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident Investigation		1007/	M .		Yas 2□No				
ĭ	r Atte	tific	3 ☐ Sulcida 6 ☐ Could not be determined	28a. Place of Inju- building, etc	ry - At home, farr	n, straat, fecto	ry, office	-	28f. Location (City or To	Street end Numb	per or Rural R	oute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Cer								, - ,		
	4 hour	edical	(Check only 2 Medical Exam	ysician: To the best o	f my knowledge, examination end	deeth occurre	d et the tim	e, dete end pointion, deeth	place, and dua to the occurred et the time.	causa(s) end me	enner es stete	ed. e ceuse(s)
	the the mple	Med	one) 29b. Signeture and title of certifier	end menner ste	ted.							
	5 7 ½ 5 8			and d	M. 1.		Oc. Licanse			29d. Date signe		
	1.1		Walid Along				1000	212	6 ABO	INKC	77 >0	2 (3)0
	INI		30. Name and address of person who of 5 2 0 DONACH	R Cause of de			WH	6/13	17150	of me	0 17	-
	Sta	te	BALT (MOR 31. Dete filed (Month, Dey, Year)	32 Registre	r's Signeture	1239	1					
	Registr		APR 0 1 1998	Julia No	widow D.	1.00						

DHMH 16 Rev 6/95



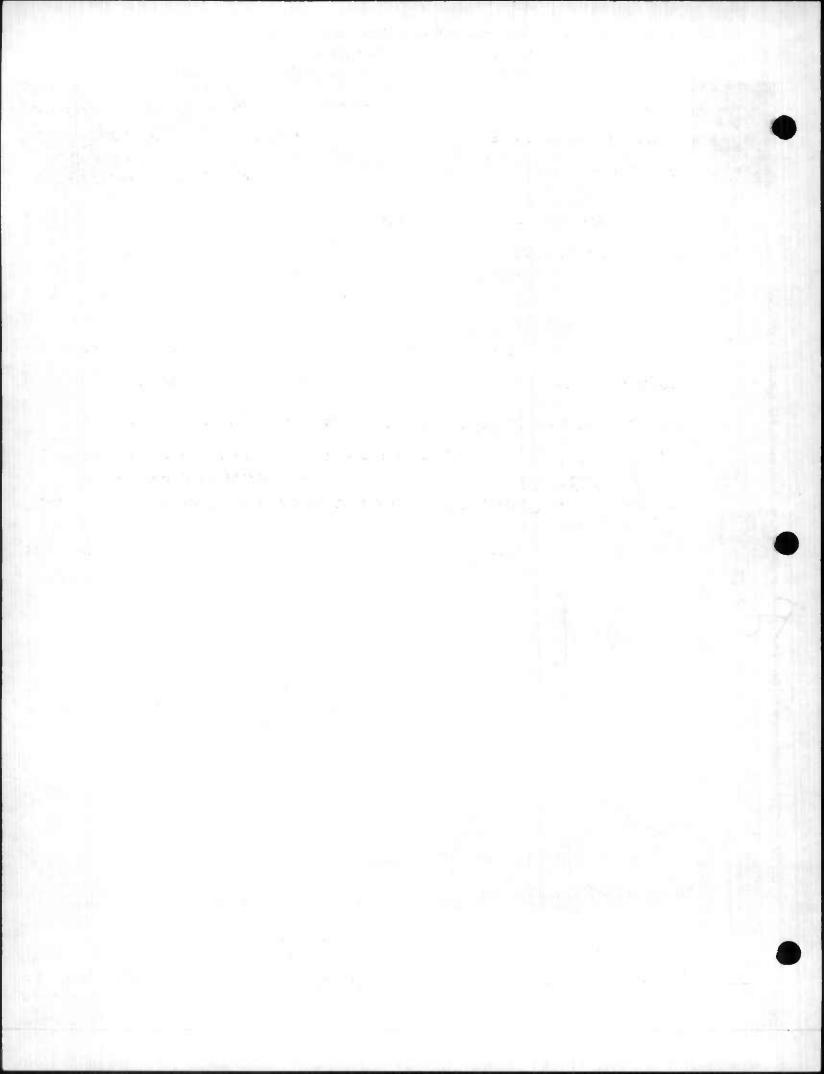
State of Maryland / Department of Health and Mental Hygiene 98 10286

					Cei	rtificate (of Deat	h		Reg. No.		1.00
Physician		1. Decedent's Nema (First, Middl				MITT	ED		. Data of De		Yeer	3. Time of Deeth
/Medical	1	GEORGE		ILLIP		MILL			ARCH	23, 199	98	7:15 PM
Examiner	ľ	4e. Facility Nama (If not institution MARINER OF NOF	A COLUMN TO THE REAL PROPERTY OF THE PARTY O	S. S. India			GLEN	Town, or Loca BURNII			y of Death ARUNDE	EL
Funeral Director		5. Social Security Number 216-01-7050	6. Sex 1 € M 2 ☐ F	7. Age (In yrs. le 91	st birthday) Yrs.	If Undar 1 Y Months Da	aar If Und ays Hours		Date of Birt (Month, Da)			ca (State or Foraign 1) 10RE, MD.
*_	-	Usual Rasidance of Decedent 10a. Stata 10b. County		10c, City.	Town or Lo	cation					100	I. Insida City Limits
f show		MARYLAND ANNE A	RIINDEI.		BURNI						100	1 ☐ Yes 2X No
ms 23a or 28a-f show trivial be notified at neral Director		10e. Street and Number 204 CHALME		ODE!	BORRI	10f. Zip Coo 2106				10g. Citizan of U.S.A		n
al', or its	2	11. Marital Status 1 □ Never Marriad 2 □ Marri 3 ፟ Widowed 4 □ Divorcad	Armed Fo	2 ∰No ⁄a	1	Ves Decedant 1 Yas, specify (1 □ Yas 2 □	Cuban, Mexic	Origin? (Specifican, Puerto Ric	ly Yas or No- can, etc.)		ce - Amarican ck, White, at WHIT).
lygiana. her than "natural", ht, tre Medical Ex-	mbieren	15. Decedan (Specify only highan Elementery/Secondary (0-12)	t grada complated)	-4or 5+)	(Giva lifa. l	DO NOT usa re	ona during m	ost of working		16b. Kind of B		
d out	Elementery/Secondary (0-12) College (1-4or 5+) CHAUFFER 17. Father's Name (First, Middla, Last) GEORGE P. MILLER 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or in the content of the c								YELLOW CAB COMPAN Nama (First, Middle, Maidan Sumame) (UNKNOWN)			
th end Menta 7 is marked traumatic ev	-	19a. Informant's Name/Raiations	nip (Type, Print)		19b. Mailir	ng Addrass (St	reet and Num	nber or Rural F	Routa Numbe	er, City or Town	, Stete, Zip C	ode)
Health em 27 la		BARBARA A. MATT	I-GREAT N	EICE	603 V	VINTON	AVE.	GLEN B	URNIE,	, MARYLA	AND 210	061
y or o	1	20a. Mathod of Disposition 1X Burial 2 □ Cramation 4 □ Donation 5 □ Other (S		Cel	matary, crar	sition (Nama on natory or other LL CEME	place)	1	Data 27/98	20c. Location BROOKI		n, Stata ARYLAND
Departmen Important: any Injury once.		21. Signature of Funaral Service	Licensee	1						FUNERA EN BURN		
hysician /Medicai xaminer		Enter the disease, or whock, or heart failure. List Immediate Ceuse (Final disease or condition resulting in death)	4	ng Co	lu (uanca of):	-				C	itarval Between insat and Death 3 would
ing phy e as the bu	5	Sequantially list conditions, if any, leading to immediate cause. Entar Undarfying Causa (Disease or Injury that initieled avants rasulting in death) Lest	c		as a conseq							
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een signed by the attend hould be detached for us eted by Physician/	, , ,	Part II. Other significant condition	ns contributing to de	eath but not result	ting in tha u	ndarlying caus	a givan In Pa	rt I.	23b. Did 1			he cause of death?
2 s Die	Bosonia									en autopsy med?	availe	autopsy findings able prior to plation of cause ath?
cate ha									101	Yes 25No	101	res 2 No
this certificate ral director, pag	3 3	25. Was case referred to medical axaminar?	Hospital:				Other	ece of Deeth (0				
00	1 Inpatient 2 Envoutpatient 3 DOA 4 Nursing									denca 6 Oth		
rs aftar death. al Director: After t led in by the funera Certification:		3 Suicide 6 Could a detarm	nad Zoa. Placa	of Injury - At hom	na, ferm, str	aat, fectory, off	ice	28f	Location (S City or Tox	Street and Num. vn, Stata)	ber or Rural F	Routa Number,
Funer Funer Itely fill	29a. Cartifiar (Check only one) 1 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and plece, and dua to tha causa(s) and mannar as (Check only one) 20 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, daath occurred at the tima, deta end plece, and due and mannar statad.									annar as stat and due to th	ed. na causa(s)	
To the comple	1	29b. Signature and title of certifial	de /m	ged a	un.	29c. Lic	ense number	20		3 Q	5/98	y, Year)
0(-	Name and address of parson and the state of	M.D	a of death (Itam a	MC	Print)	UN	Ra.	Pasa	dura	Mol. 6	21122

Registrar

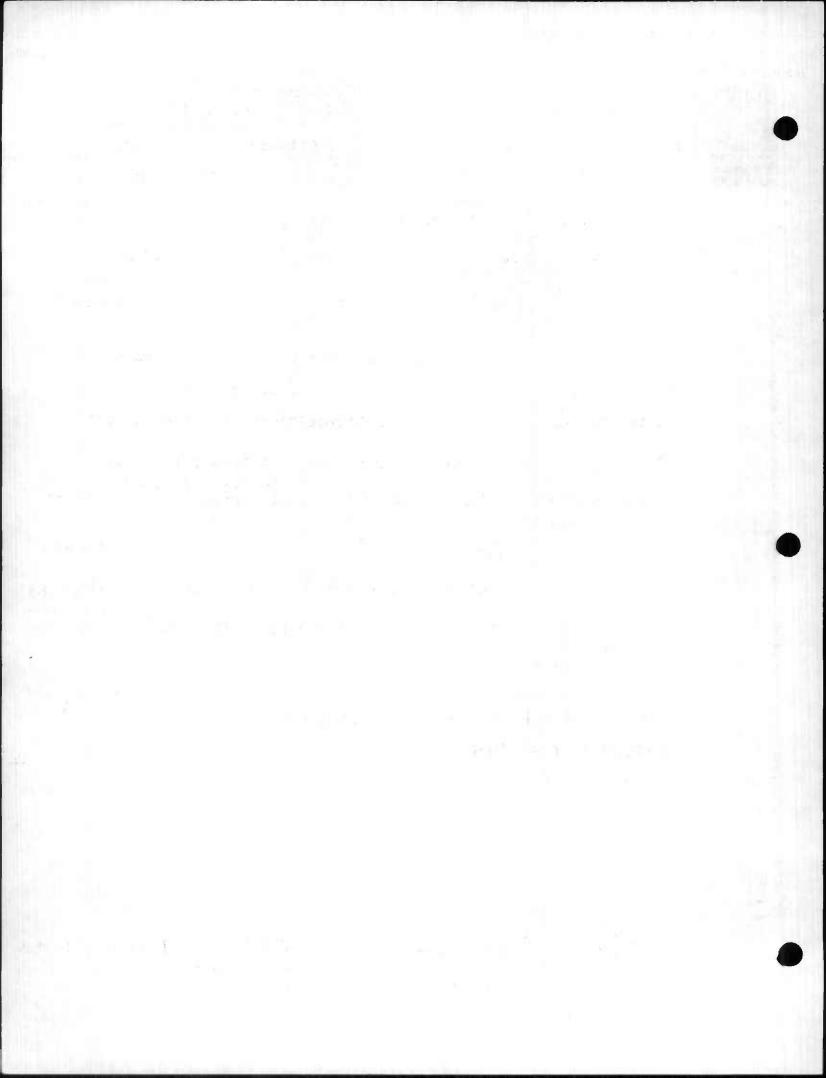
DHMH 16 Rav 6/95

APR 0 1 1998 Julia Favidan Bondace



State of Maryland / Department of Health and Mental Hygiene

					iai y iai ia		tificate of	Death		Reg. No.	-	0287
	100		1. Decedent's Neme (First, Middle,	Last)					2. Dete of De	ath	v	3. Time of Death
	Physici /Medi		Tommie Le	e Miller					Month 03	29 98	Yeer }	9:50 P.M.
	Examir		4e. Facility Name (If not institution,	give street and number	-)			4b. City, Town, or I	Location of Deeth			
	Funeral Director		Southern Mary 5. Sociel Security Number 544-54-8054		oital ge (In yrs. Wes	st birthday) Yrs.	If Under 1 Year Months Days			h y, Year)	9. Birthp Coun	
Н	D		Usuel Residence of Decedent						, , , , ,		1COT	yıa
	how		10a. State 10b. County			Town or Loc					1	Od. Inside City Limits
	Ba-f	cto	MD P.G.		C:	linto	n					1 X Yes 2 No
	ath with the Marylan 23a or 28a-f show	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of W		itry?
	ath w	<u>a</u>	7311 Seawood				207			U.S.		
020	72 hours efter death with the Maryland natural', or items 23a or 28a4 show dical Examinet must be notified at	by Funeral Director	11. Meritel Stetus 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Detes:	? No		Vas Decedent of I Yes, specify Cub ☐ Yes 2☐ No	Hispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race Blec Specify	k, White,	een Indien, etc. ack
21215-0020	"natur	Completed	15. Decedent's (Specify only highest	Education grade completed)		16e. Deced	ent's Usuel Occup	petion during most of world)	king	16b. Kind of Bu	siness/Inc	yntaut
12	within ene.	ошо	Elementary/Secondery (0-12)	College (1-4or						Dwin		
	Hygin Hygin	Ö	17. Father's Name (First, Middle, La	st)		Day C	are Pr	18. Mother's Nen	ne (First, Middle,	Priva Meiden Sumem		
Maryland	should be and Mental s marked o	To Be	Tom Smedley					- 16	e Taylo			
ary	shou ind M imar	-	19e. Informent's Neme/Relationshi	(Type, Print)		19b. Meiling	g Address (Street	end Number or Ru			Stete, Zip	Code)
Σ	and 2 eith a 27 is		Thelma Brand	on		731	1 Seaw	ood Cou	rt Cli	nton, Mc	1. 2	0735
Baltimore	permit. Peges 1 and 2 should be filed within 72 hours Depertment of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other treumatic event, the Medical Exa ODGS.		20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spe		cen	netery, crem	eition (Neme of etory or other ple Cemete		Dete /2/98 S	20c. Location		
alti	Depertm Importar any Injui		21 Signature of Funeral Service Li	**)			ess of Facility HO				
111	205 = 2		1 Junice &	dward		39	10 Sil	ver Hil	1 RD.SI	uitland	, Md	.20746
			23a. Pert1. Enter the disease, or constant shock, or heart feiture. List or	emplications that cause	d the deeth.	Do not ente	r the mode of dyl	ng, such es cerdied	or respiretory e	rest,		Approximate Interval Between
4	Physician /Medical		Immediate Cause (Final disease or condition		EPS:						•	Onset end Death 24 HR5
	Examiner		resulting in deeth)	θ	Due to (or e	s e consequ	uence of):					C.
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	and -trens	Examiner	Sequentially list conditions,	0.	Due to (or e	s e consequ	uence of):					MORE THAN
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	ding	Me		d							j	
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P.O.	the d	iysi	Part II. Other significant conditions									the cause of death?
	requires that the death centificate be executed seen signed by the ettending physician and hould be detached for use as the burial-trensit	þ	Chronic R	enal fa	ilure	2 01	n Dial	ysis.		Yes 2□No		/,
Records,	Z S T	Completed	Diabetes						24e. Wes perfo	en eutopsy med?	cor	ere eutopsy findings eiteble prior to mpletion of cause deeth?
_	lelan: The law certificate has b rector, page 2 s		Peripheral	Vascula	e dis	ease	೭.		101	res 2 No	1[☐ Yes 2☐ No
of Vital	Physician: this certific ral director,	Be (25. Wes case referred to medicel examiner?	Hospitel:	V		Ott	26. Plece of Dee				
of	Phys this ral di	: To	1 ☐ Yes 2 No 27. Menner of Death	1 L Inpati		R/O utpatio nt 8b. Time of	3LI DON	4 LJ Nuising H	ome 5 Resid	lence 8 Other		(N
o	After After	tion	1 Naturel 5 ☐ Pending	28e. Dete of injui	y Year)	Injury	28c. Injur Woo	rk? Yes 2 □ No	200. Describe i	low injury occurr	5 0	
Division	10 to 0	Certification:	3 ☐ Suicide 6 ☐ Could no	be one place of le	iury - At home	e ferm stre		163 2 160	28f. Location (5	Street end Numbe	er or Rure	al Route Number
1 a	100	ert	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)									.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	o the	₩ W	29b. Signature engine of certifier	611011110111101 51			29c. Licens	se number	T	29d. Date signed	(Month.	Dey, Year)
	- 3 - 6			and him	MINA							
			30 Name and address of posses with	a completed assess of	dooth /lto o	20) /Turns 7	Print) GVA	T CHAND	51100	4 II	лсп	2-111 000
0			30. Name and address of person with Suit = 307.	SOL SURI	PATT	Con (Type, P	AD /	T LENTERS	JUKA I. M.D	207	35	
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Baltimore, Maryland 21215-0020

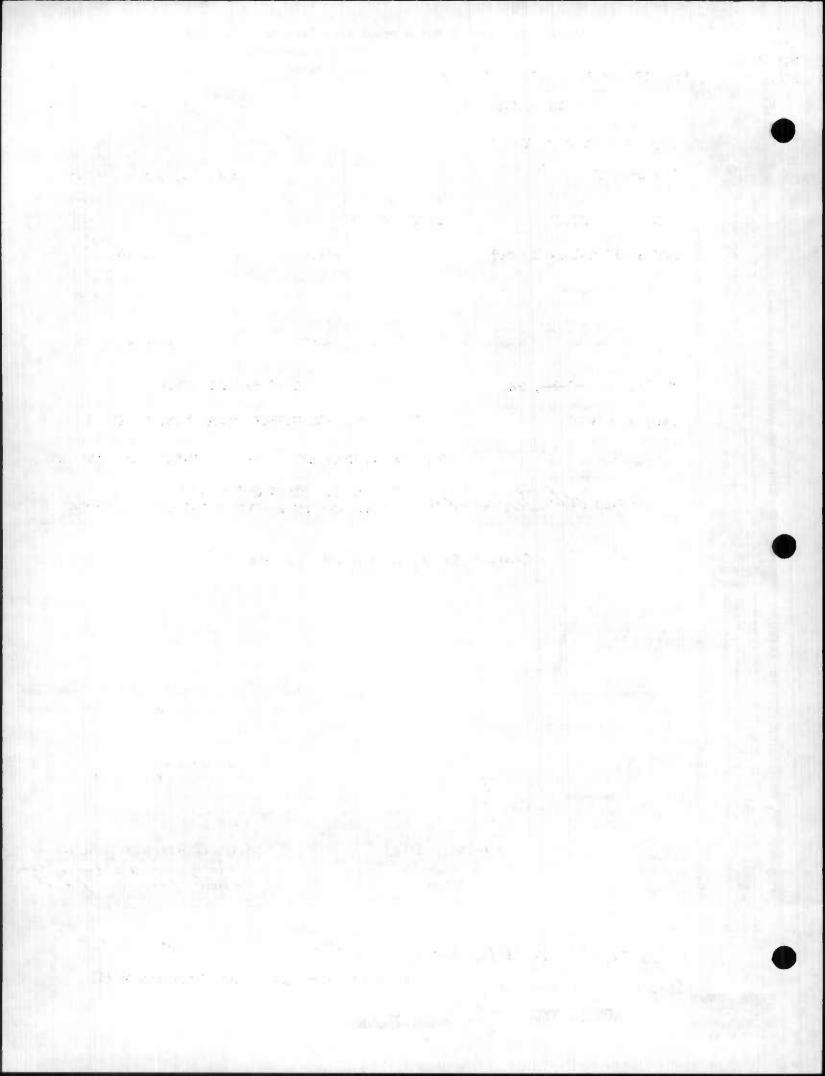
Division of Vital Records, P.O. Box 68760,

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IAM AN	Item:17 per F.H.		-	0-	ertificate of	Health and I Death		giene 9 8	10	288		
	1. Decedent's Name (First, Middle, L.	eeth Dey	Yaar	3. Tima of Death								
Physician /Medical	WILLIAM EDWARD						MARCH	27, 1998		20:25 PM		
Examiner	4a Facility Neme (If not institution, g		nber)			4b. City, Town, or I		h 4c. County				
	802 SOUTH CURLES. Sociel Security Number 6.		7. Age (In yrs. i	lest hirthday	If Under 1 Year	BALTIMOI If Under 24 Hrs.		rth .	9 Ridbolec	a (Stete or Foreign		
Funeral Director	217–54–2253	™ 2□ F	46	-	Months Deys		(Month, De	ay, Year)	Country)			
	Usuel Residence of Decedent						MARCH	29,1951				
show	10e. Stete 10b. County			y, Town or L					10d.	Inside City Limits		
Sa-f s	MD CITY		B	ALTIMO	DRE CITY					Y Yes 2 No		
Direct Di	10e. Street end Number 802 SOUTH CURLEY	יוים בים מיוים			10f. Zip Code	224		10g. Citizen of V	Whet Country	7		
eral	11. Meritel Stetus		dent Evar in U,	S 13.		ムムコ Hispanic Origin? (S	pecify Yes or No	1 11 2	a - American	fndien.		
2 should be filed within 72 hours after death with the Maryland and Mental hygiene. In marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Exercise must be notified a To Be Completed by Funeral Director	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed For 1 Tes If Yes, Give Year or De	ces? 27 No		If Yes, specify Cub 1 ☐ Yes 2 No	oan, Maxican, Puart	o Rican, etc.)		ck, White, etc.			
2 hours	15. Decedent's f	Education		16a. Dece	edent's Usuel Occu	petion		16b. Kind of Bu	usin ess/Ind us	try		
ed within 72 ho ygiene. nor then "neturn rt, rr. Medical Completed	(Specify only highest g Elementary/Secondery (0-12)	rade completed) College (1-	-4or 5+)		DO NOT use retire		king	D.L. WILLOW	VDT III			
od with	8				MECHANI			AUTOMO				
Mental Hy inked oth itic event	17. Father's Neme (First, Middle, Las WORG WILLIAM E. MARCE								ne)			
permit. Pages 1 and 2 should be filed within 72 hours begardnand to Health and Mental Hygiene. Important: if item 27 I a marked other than "natural", any injury or other traumatic event, in the month once. To Be Completed by	19e. Informant's Name/Reletionship DALE W. MORGAN	(Type, Print)	Type, Print) 19b. Meiling Address (Street and Number or Rurel 907 S. POTOMAC STREET						Stete, Zip Co 21224			
of He	20a. Method of Disposition 1 Burial 2 Cremetion 3	□ Bomouoi from S	0		osition (Neme of emetory or other ple	eca)	Dete	20c. Location -	City or Town	, Stete		
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n 24 house no 24 house he Fune	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner as stated. 29b. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse end menner stated.											
To the complete complete Me												
	30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)											
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Registrar

APR 01 1998 Julie Swidson Fandage



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Day Heles 1998 12:57 Ar MARC 31 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death HERTIALS If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HARFORD ADODAA If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 280 F Months Days OP Yrs. 188 09 1950 Usual Residence of Decedent (YZOOZY) 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No HARFERD MARYLAND FALLST 00 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? iRI 31040 2716 LOURT 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status Black, White, etc. 1 ☐ Yes 2 No 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: TIHW 3⊠ Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) - Homs Homemaker 12YRS 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Name (First, Middle, Last) KEBERCA CHALFANT BENJAMIA 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD 271612 FALLSTON, MARYLAND RKSHIRS Buo 20b. Place of Disposition (Name of cemetery, crematory or other place) PPRU1 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 Cremetion 3 ☐ Removal from State 1998 4 ☐ Donation 5 ☐ Other (Specify) Sound Rangiory BALTIMORS MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility CHAPIL-BURIR, P.A' 21050 EVANS FUNSRAL 23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. 1ARYLAND Approximate Intervel Between Onset and Death consestive Heart Failure Immediate Cause (Final disease or condition resulting in death) CHRINIC OBCTRUCTUR PULMONARY DISCUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 M No 1) EMENTIA 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medicai Examiner

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7 is marked other than "naturel", or items 23s or traumatic event, tre Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Important: If item 27 is marked other than "naturel", or Nema 234 any injury or other traumatic event, tre Medical Examiner mans.

Baltimore, Maryland 21215-0020

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> Examiner physician and the bunal-transit Physician/Medical by

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The law requires that the death certificate be axecuted is certificate has director, pege 2 Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifice n 24 hours after dea ne Funeral Director nletely filled in by th To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

Medical State Registrar

25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: ⊅⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 5 Pending Naturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide

TSC Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature end title of certifier

29c. License number 050232 29d. Dete signed (Month, Day, Year)

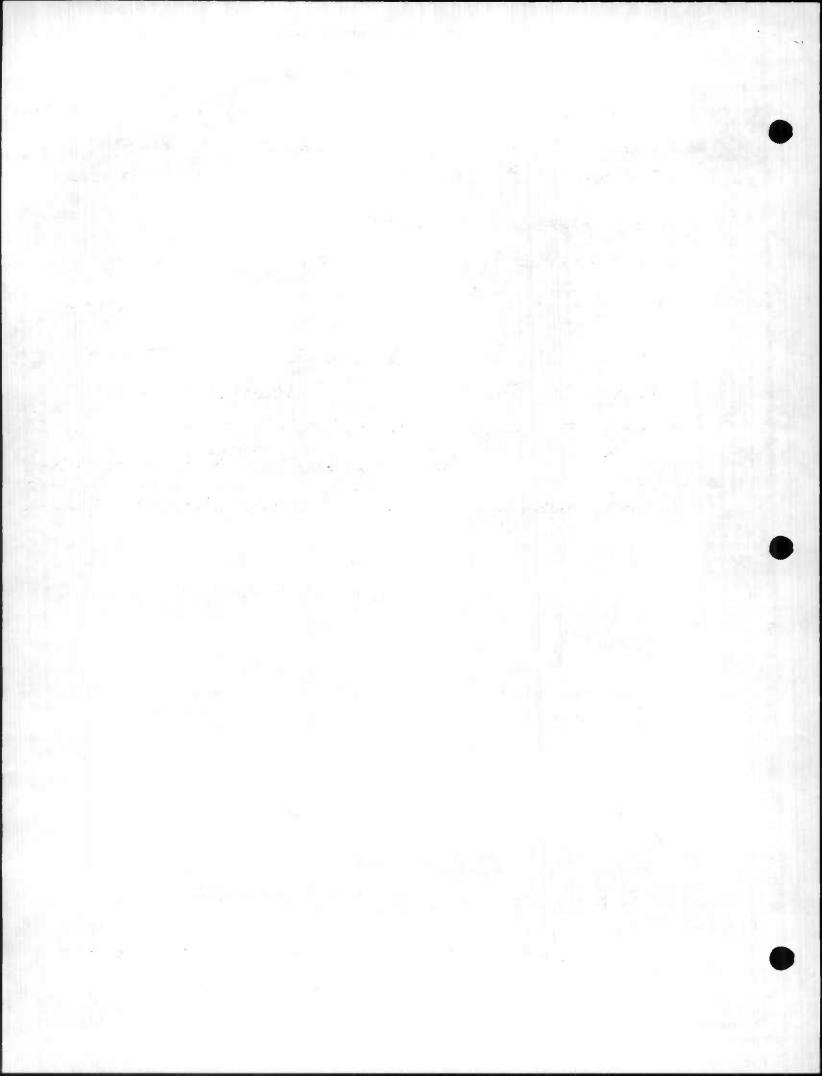
MO MPH 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

CYRUS HAMIDI MD PAPERMILL RD PHOENIX MD 21131 3346

31. Dete filed (Month, Day, Year) APR 0 1 1998

32. Registre's Signature

Funa Daydon - Randall



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Carl Wayne Mc Entire **Physician** 1998 12:48 A.M. 31 March /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Baltimore Rosedale Franklin Square Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 061–18–4632 **Funeral** Months Days Hours 1⊠M 2□F Yes Director 12/31/1926 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 ☑ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 3704 Double Rock Lane 21234 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours after 1 □XYes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 Married 1 ☐ Yes 2√☐ No Specify: White p 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Baltimore County permit. Peges 1 end 2 should be filed of Department of Haalth and Mental Hygie Important: If Item 27 is marked other? 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Neme (First, Middle, Last) Wayne Mc Entire Jessie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene Paluzzi 6928 North River Drive Baltimore, maryland 21220 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriei 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 4/3/98 Baltimore, Maryland Garden of Faith Cemetery 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Dippel Funeral Home Inc. anton 7110 Belair road Baltimore, Maryland 21206 23a. Part1. Enter the disease shock, or heart failure the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medicai Acute Myocardial Infarction 30 minutes Examiner Due to (or es a consequence of) Examiner attanding physician and I for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as e consequence of) Physician/Medical Due to (or as a consequence of): resulting in death) Last ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t d be detech X Yes 2 No 3 Probably 4 Unknown Abdominal Aortic Aneurysm þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peed Large Abdominal Wall Hematoma certificate has pega 2 1 ☐ Yes 2 No 1 Yes ZONo Chronic Obstructive Pulmonary Disease or Attending Physician: ours after death.

•rai Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 70 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner stated. (Check only

To the Hospital within 24 hours a To the Funeral C completely filled

Box 68760.

P.O.

Division of Vital

64/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and time of distribution

Dr. Thomas F. Burke 9000 Franklin Square Drive Baltimore, Maryland 21237

29c. License number

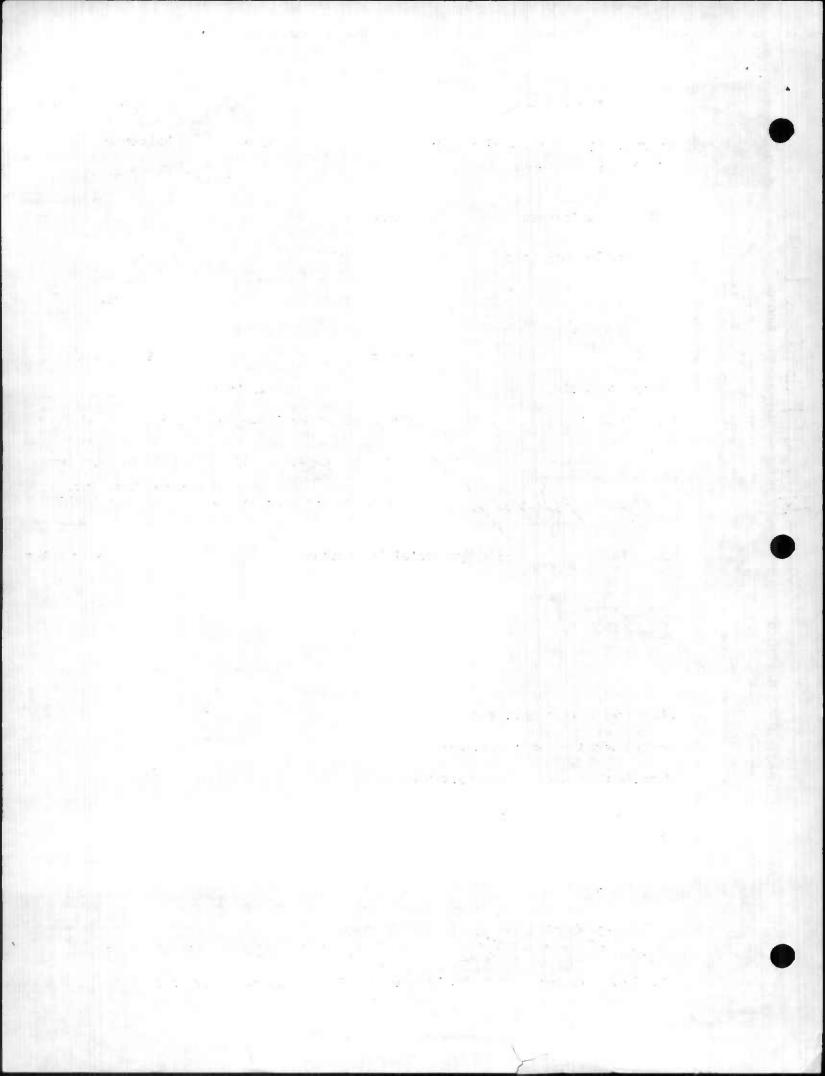
29d. Date signed (Month, Day, Year)

March 31 1998

31. Date filed (Month, Day, Year)

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Registrar



98-1771-510

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JOHN

State of Maryland / Department of Health and Mental Hygiene

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Items: 23 part I,27 per MEO G-758 4/24/98 Certificate of Death

37

2. Dete of Death Day

FIIYSICIAII
· /Medical
Examiner

John Michael Mc Laurin 4a Facility Name (If not Institution, give street and number)

1. Decedent's Name (First, Middla, Last)

4006 FLEETWOOD AVE

Month MARCH 4b. City. Town, or Location of Death

8. Date of Birth (Month, Day, Year)

03/19/1961

3. Time of Death Vaar 30, 1998 4c. County of Death

7:05A.M.

Funeral Director

death

filed within 72 hours after

Hygiene.

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Physician

/Medical

Examiner

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Division of Vital

Physician:

Hospital or Attending

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Physician/Medical

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Certification: To

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altimore, Maryland 21215-0020

214-88-7217 Usual Residence of Deceden 10a. State 10b. County

5. Social Security Number

BALTIMORE
If Undar 24 Hrs. 8. 5 If Under 1 Year 7. Age (In yrs. last birthday) Days Hours Min. Vrs

10f. Zip Code

1 ☐ Yes 2 ☐ No

21206

 Birthplaca (State or Foreign Country) Maryland

the Maryland r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

Directo

Funeral

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Completed

Be

MD **Baltimore** 10c. City, Town or Location Baltimore

10d. Inside City Limits 1 ☐ Yas 2 ☑ No

10e Street and Number 4006 Fleetwood Avenue

11 Marital Status

12. Was Decedent Ever in U,S. Armed Forcas?

1 3 M 2 □ F

13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)

Specify: White 16b. Kind of Business/Industry

20c. Location - City or Town, State

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12

College (1-4or 5+)

Merchant Marine

10g. Citizan of What Country?

U.S.A.

17. Fathar's Name (First, Middle, Last)

Ernest Mc Laurin

Dolores Pusateri

19a. Informant's Name/Ralationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8717 Oakleigh Road Baltimore, Maryland 21234

Robert De Rosa

20b. Place of Disposition (Name of comatery, crematory or other place)

Seaman

20a. Method of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)

Baltimore/Washington Crem, 4/3/98 Laurel, Maryland 22. Name and Address of Facility Dippel Funeral Home Inc.

18. Mother's Name (First, Middle, Maiden Sumame)

21. Signeture of Funaral Service Licensee ranton

7110 Belair Road Baltimore, Maryland 21206 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA COMPLICATED BY DRUG USE

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

Due to (or as e consequence of):

Due to (or as a consequence of):

that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

Unknown 3 ☐ Probably

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of causa of death?

25. Wes case referred to medical examinar? 1 Yas 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Nothar (Specify) IN CAR

27. Manner of Deeth 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be 28b. Time of 28c. tnjury at Work? 1 Tyes 2 No 28d. Dascribe how injury occurred

29a. Certifier (Check only

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifian

29c. Licanse number

29d. Dete signad (Month, Day, Year)

O.C.M.E.

MARCH 30, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of each (item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

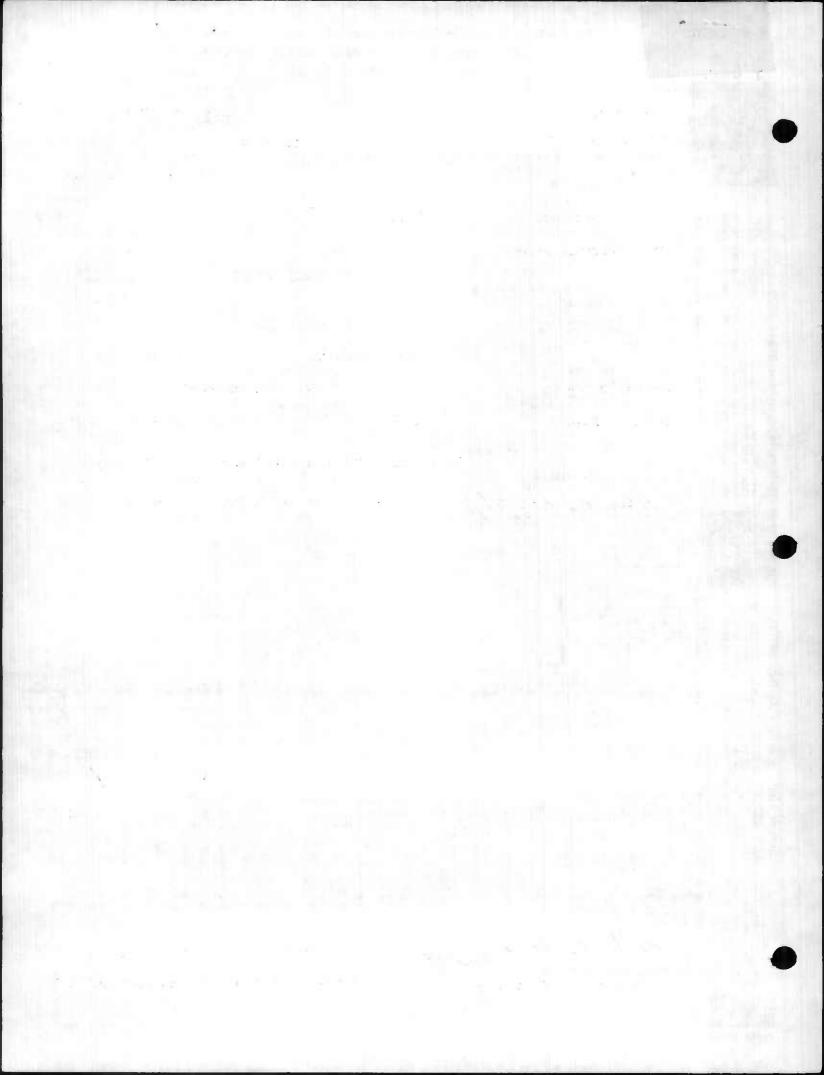
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mort M. 31. Date filed (Month, Day, Year) 1998 APR 01

2. Registrar's Signature a New doon-Randoll

State Registrar

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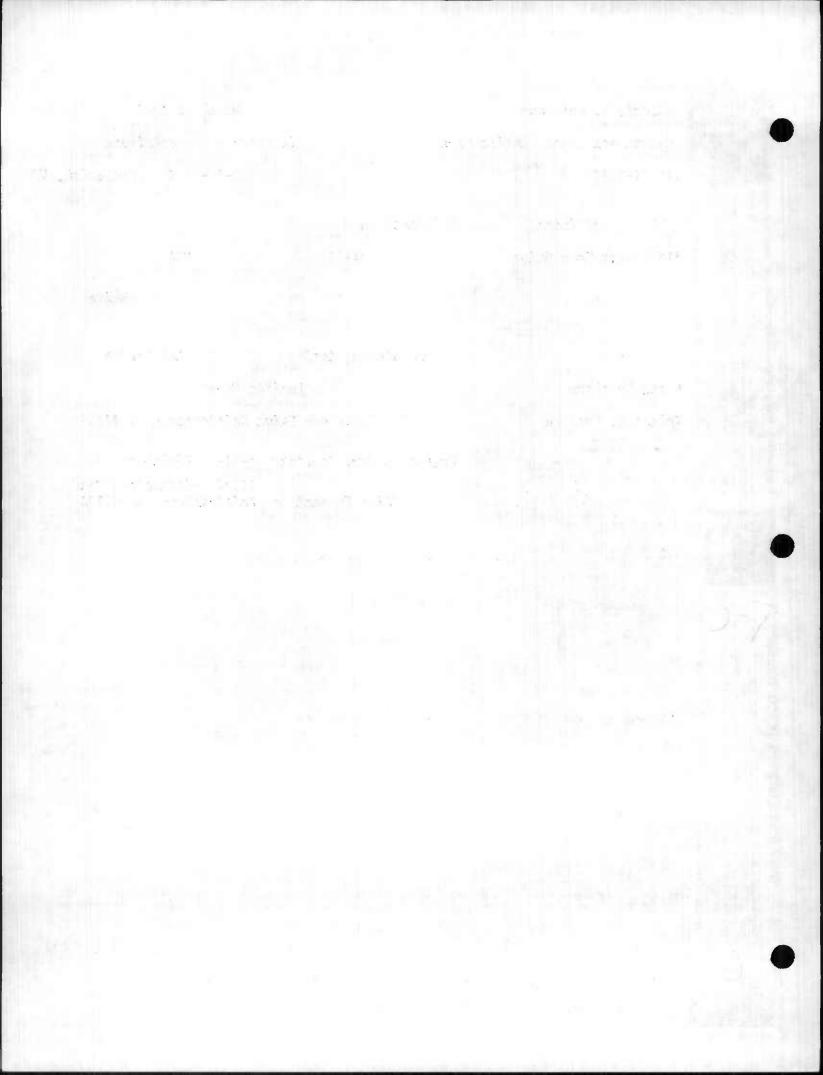
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** March 28, 1998 Earle R. Nussbaum 12:07am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Cherrywood Manor Nursing Home Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₩M 2□F Yrs. Director 212-09-3224 9-19-1909 Frederick. MD Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examines must be notified at 1 ☐ Yes 2 WNo Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11705 TerryTown Drive 21136 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer Department of Health end Mental Hygiena. In mortant: if Item 21 is mericed other than "natural", or thei any Injury or other traumatic event. 1 Yes 2 No it Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: White à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 9 Bethlehem Steel Lab Tester 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Harry Nussbaum Lucille Unger 19a. Intorment's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Nussbaum 11705 TerryTown Drive Reisterstown MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13-31-98 Finksburg. MD Evergreen Mem. Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 11824 Reisterstown Road mi Eline Funeral HomeReisterstown, MD 21136 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical cardiovas en las disease Arterosclerotre **Examiner** Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknown vascular d. Methacilla sensitive 24b. Were eutopsy findings evailable prior to Completed 24a. Was an eutopsy performed? Stroke completion of cause of death? Congestive heart falure 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese reterred to medical exeminer? 28. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural or Attending 5 Pending eftar death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 35844 March 30, 1998 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) D Roggen Owings mills mo 2M7 21 Crossroads Drive

State Registrar 31. Date tiled (Month, Day, Year)
APR 0 1 1998

32 Registrars Signature
Julian Davidson-Randolle



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (Fjrst, Middle, Last) 2. Dete of Deeth Month Dev **Physician** March 29 dwar 6:43 A.M 1998 11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) Examiner Ba Harbor 25 Ltimorp 105 9 If Undar 24 Hrs. If Under 1 Year 6. Sex 1200 M 2 ☐ F Birthplace (State or Foreign Country) 7. Aga (In yrs. lest birthday) 8. Deta of Birth (Month, Dey, Yeer) 5. Social Security Number **Funeral** 74 Months Deys Hours Director 212-28-0342 04 08 1923 Maryland Usual Residence of Decedent with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d, inside City Limits 28a-f show / is marked other than "naturel", or items 23a or 28a-f show trsumatic event, the Medical Examinal must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Co. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Berlin Avenue 21225 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after deeth 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 10 No if Yes, Giva Year or Dates: 14. Race - American Indian, 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 Yas 2 No Black Baltimore, Maryland 21215-0020 Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grede comp ede completed) al Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) Secondary Heavy Machine Operator Brick Yard 18. Mother's Name (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Department of Heelth end Mental Important: If Item 27 is marked o Archie Oliver Isadore Oliver 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Ola Mae Oliver/Wife 103 Berlin Avenue. Baltimore, Maryland 21225 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Mathod of Disposition 1 XBurlai 2 ☐ Crametlon 3 ☐ Removal from State injury or Maryland Veteran Cemetery 4/3/98 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Fecility 21. Signature of Funeral 1206 W. North Avenue, Baltimore, Maryland 21217 e. List only one ceuse on each line. William C. Brown Community Funeral Home 23a. Part1. Enter the cheas shock, of heart feilure. interval Between Onset and Daath **Physician** /Medical Immediate Cause (Finai disease or condition resulting in death) Examiner disease Physician/Medical Examiner 00010 attending physician and for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Due to (or as a consequanca of): 80 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the 1 Yes 2 No 3 Probably 4 Unknown signed by by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy Completed peen has 1 Yes 2 No 1 Tes 2 □ Ne certificate Physician: Be 25. Was cese referred to medicei examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1 Ves 2 No 1 ☐ Inpatient 2 ☐ Ributpatient 3 ☐ DOA this Director: After this d in by the funeral 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of Certification: 5 Pending investigation or Attending 1 Naturel 1 Yas 2 No death. 2 Accident 6 Could not be 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 | Homicide 24 hours the Hospital 29e. Certifier 1 🔀 Carlifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and manner es steted. edicai 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier deeth (Item 23e) (Type, Print) GERALO A POLLOW, 30. Name and address of person who completed cey bor 300 5, 31. Date filed (Month, Day, 32. Registrer's Signature State

Registrar

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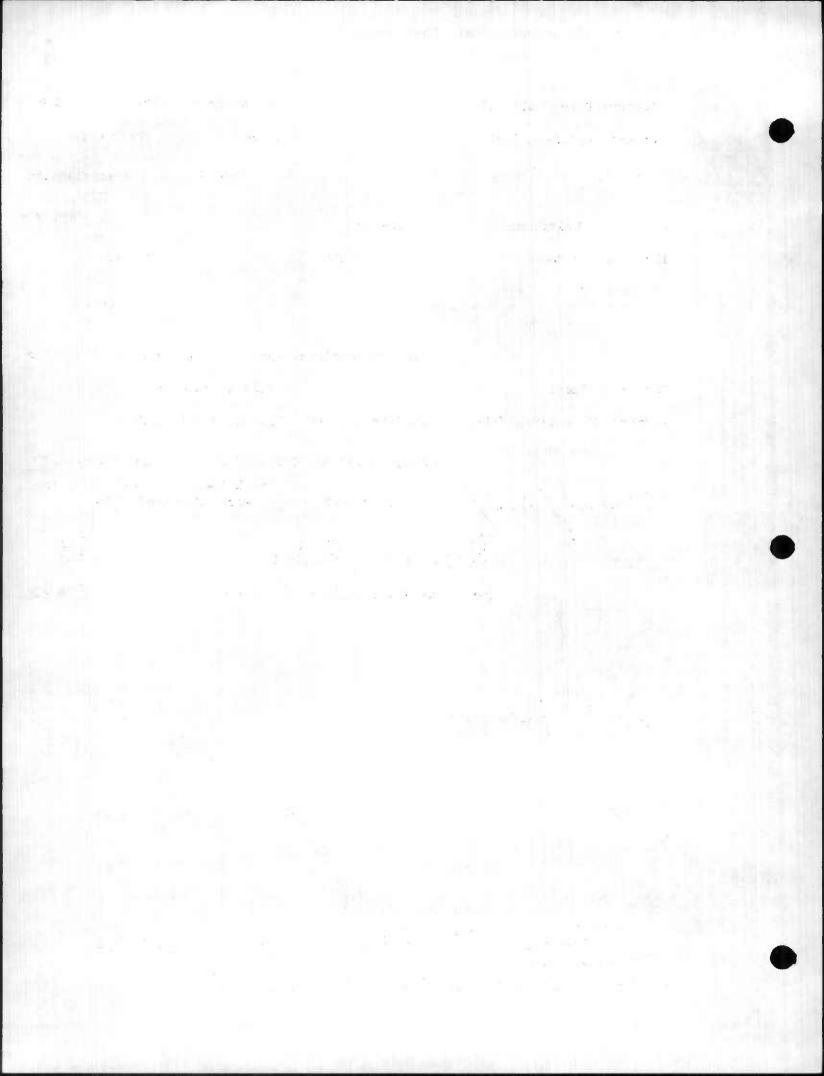
Notyland Veteran Cemetery 4/L/SS PrograyIlle, Maryland

William C. Brown Community Timerel Fone

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			C	ertificate of	Death	R	eg. No.	1 (
Physician	1. Decedent's Neme (First, M					2. Date of Deet Month	Day	Year	3. Time of Death
/Medical		ter Polimen				March 30			5:00 PM
Examiner	4e Facility Name (If not institution Genesis Mu	ution, give street and num lti-Medical	nber)		4b. City, Town, or Loc TOWSOI		4c. County	of Death altim	ore
uneral	5. Social Security Number		7. Age (In yrs. last birthd	last birthdey) If Under 1 Yeer If Under 2		8. Date of Birth (Month, Day,	Veer	9. Birthpi	lace (State or Foreign try)
ector	029-18-7415	1€M 2□F	72 Yrs	Months Days		May 29,			achusetts
	Usual Residence of Decedent 10e. State 10b. Cou		10c. City, Town or	Location				11	0d. Inside City Limits
ō		7.1							1 ☐ Yes 2 ☑ No
Funeral Director	Md. E	Baltimore	1	OWSON 10f. Zip Code		1	0g. Citizan of V	What Coun	try?
٥	1589 Doxbury	, Poad		21286			II S	S.A.	
Jera	11. Marital Status	12. Was Dece	edent Ever in U,S. 1		Hispanic Orlgin? (Spe pen, Mexican, Puerto I	cify Yes or No-	14. Rac	e - Americ	
by Fur	1 Never Married 2 ☑ 1 3 ☐ Widowed 4 ☐ Divor	If Yas, Giv	2 No	If Yes, specify Cut		Rican, etc.)	Specify		ite
8		dent's Education	16a De	cedant's Usual Occu	pation		16b. Kind of Bu		
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EO	Contamary/Secondary (0-1	2) College (1		Md. Nati					l Banking
Be Completed	17. Father's Name (First, Mid	dle, Last)			18. Mother's Name	(First, Middle, I	Meidan Sumem	ne)	
Tol	Joseph Polir	neni				A. And			
J.	19a. Informant's Name/Relati				t end Number or Rure				Code)
	Margaret M. 20a. Method of Disposition	Polimeni/W:		Doxbury sposition (Neme of	ra. Towso	n, Mary	20c. Location -		um State
	1 ☑ Buriel 2 ☐ Cremeti	on 3 Removal from	Stete cemetery,	remetory or other pla	1				
•	4 Donation 5 Othe		Dulaney	Valley M 22. Name and Addr	em Grds. 4	/3/98	Timoniu	ım, M	aryland
Important: If frem any injury or othe phos.	21. Signature of Funeral Sender 12. Signature of Funeral Sende	Il Rend	used the death. Do not	1050 York	Ruc Road Tow	son, Ma	ryland		ome, Inc. 4 Approximata Interval Between
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the burial-transit	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or injury	b	Dua to (or as a con		A OT L	LW 6			MOMINS
the bur	cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last	c	Due to (or as a con	sequence of):					
0	Pert II. Other significent con-	d.	eath but not resulting in th	e underlying cause g	iven In Part I.	23b. Dld to	obacco use co	ntribute to	the cause of deeth?
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by i	1701	Muur	7 3111					1	
eted						24a. Was a perlon	in autopsy med?	CO	ere autopsy findings ellabla prior to mpletion of cause daath?
Сотр						1 🗆 Y	es No	10	Yes 2 No
Bec	25. Was case referred to med examiner?	dical			26. Placa of Death	(Check only or	18)		
2	1 Yes 20 No		npatient 2 ER/Outpa	tient 3 DOA		ne 5 Rasid			y)
ation:	27. Manner of Death Natural 5 Per Accident	nding 28a. Date of (Mont astigation	of tnjury h, Day Yaar) 28b. Tim Inju	y W	ury at 2 ork? ☐ Yas 2 ☐ No	28d. Describe h	ow injury occur	red	
led in by the funare Certification:	3 ☐ Suicide 6 ☐ Co	uld not be arminad 28a. Placa buildir	of Injury - At home, farming, atc. (Specify)	street, factory, office		28f. Location (S City or Town		ber or Rure	I Route Number,
Medical Ce			best of my knowledga, dasis of examination and/oner stated.						
completely filled	29b. Signatura and title of our	Altion April	MedicalAH	relix 29c. Licer) 71(8	2	3/3/	10	Dey, Year)
	30 Nama and address of per	son who complated caus	a of death (Itam 23a) (Ty		1 # 203	Baltin	ore Md	21	208
State	31. Date fited (Month, Day, Yo	Barl 22 D	egistrar's Signature	Court	1 11 000		1		

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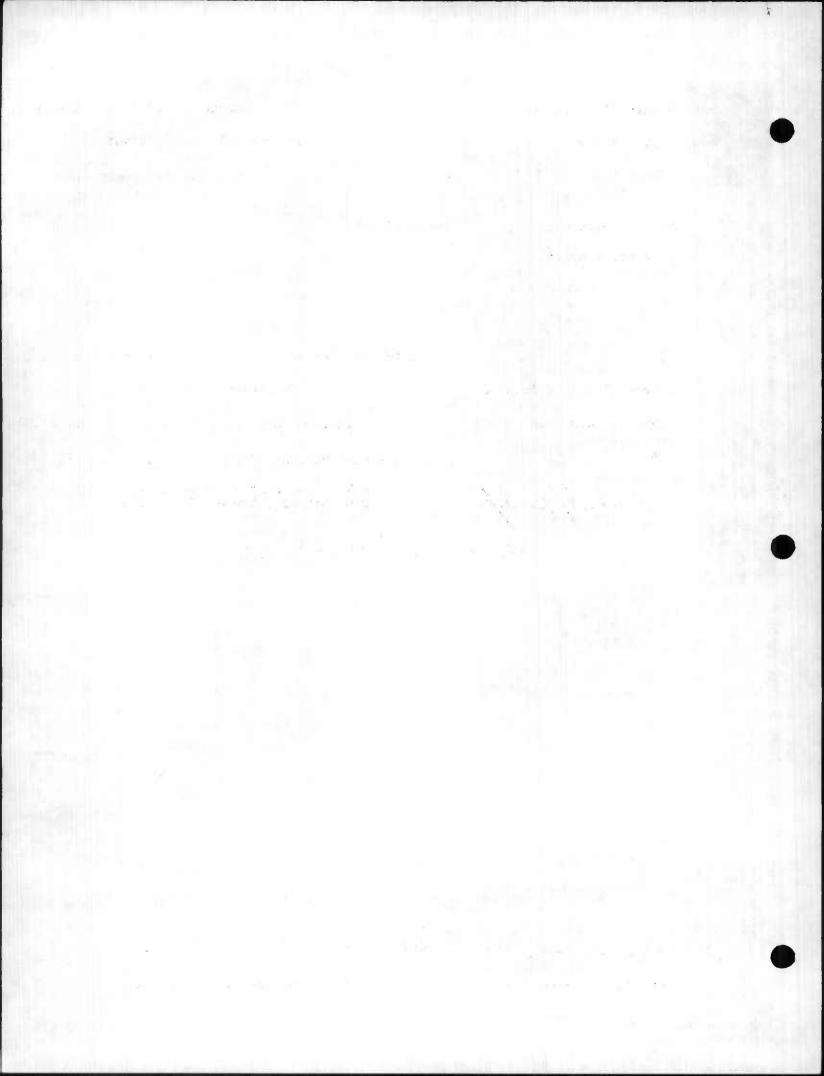


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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Dea	ath	Reg. No.	10295	
	Decedent's Neme (First, Middle, Last)	2. Dete of Month	Death Dev Ye	3. Time of Deeth	
Physicia /Medica	Howard Kilchorth Kuth		25, 1998	10:10 p.m.	
Examine	4b City	y, Town, or Location of De	eth 4c. County of D	Deeth	
8		ockeysville	Baltimo	ore	
Funeral Director	212-07-4803 1 N 2 F 79 Yrs. Months Deys Hou			Birthplece (State or Foreign Country) aryland	
pu M	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits	
h the Marylens r 28a-f show	0 - 1 - 11			1 ☐ Yes 2 🛣 No	
the h	Md. Baltimore Cockeysville		10g. Citizen of Whet	Country?	
with with	1134 Greenway Rd. 21030		U.S.A.		
ne 2%	11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic If Yes, specify Cuban, Mex	c Origin? (Specify Yes or I		American Indien,	
LZTZ15-UUZU ed within 72 hours after death with the Manyland sold within 72 hours after death with the Manyland sold within "natural", or items 28s or 28s-1 show styre Heolical Examiner must be notified at Completed by Funeral Director	3 3 Wildowed 4 □ Divorced Yeer or Detes: LTLJ TT		Casaibu	Vhite, efc. Vhite	
	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Busine	ess/Industry	
	(Specify only highest grade completed) [Give kind of work done during the black of the kind of work done during the black of the black of the kind of work done during the black of the bl	most or working			
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O EIFE	17. Felher's Neme (First, Middle, Last)	Nother's Neme (First, Midd	de, Meiden Sumame)		
arylan should be nd Mental marked o	Grover Cleveland Ruth, Sr.	Katherine Ma	ry Lentz		
Maryld 42 should thend Mer 7 is marks traumatic	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end No.	umber or Rurel Route Nur	nber, City or Town, Stat	te, Zip Code)	
	Wayne T. Ruth /son 1001 Aliceanna	a St., Apt.	1004, Balto	o., Md. 21202	
5 - 1 = E	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City	or Town, Slele	
Peges nant of int: If It	4 Donetion 5 Other (Specify) Garrison Forest Vet.(Cem. $3-30-98$	Owings Mi	lls, Md.	
Baltimo permit. Peges Department of Important: If I any injury or pnce.	medael Tuest. 1050 York I	n Funeral Ho Rd., Towson,	Md. 21204		
Physician /Medical Examiner	23a. Pert1. Enter the disee of compilerations that caused the deeth. Do not enter the mode of dying, such shock, or heart failure. Ist only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) e. Due to (or es e consequence of):			Approximate Interval Between Onsef and Deeth	
68760, ificate be executed g physician and as the bunal-transit	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest b. Due to (or es e consequence of): Due to (or es e consequence of):				
BOX 68 eath cartificat attending phy for use as th	resulting In deeth) Lest d. Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in F				
O. En deal the att	Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Pert I. 23b. D	td tobacco use contrit	bute to the cause of death?	
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Records, he lew requires th a has been signe aga 2 should be		24e. W	es en autopsy 2- erformed?	4b. Were autopsy findings evelleble prior to completion of cause of deeth?	
I Rec		11	Yes 2 No	1 Yes 2 No	
Vital Pasician: The certificata irector, pag	25. Wes case referred to medical 26. F	Plece of Deeth (Check on	ly one)		
Of Vita Physician: this certific and director,		□ Nursing Home 5 🗷 R	esidence 6 Other (Specify)	
ion of adding Physics.: After this e funeral di			be how Injury occurred		
Division of To the Hospital or Attending Physwithin 24 hours after deeth. To the Funeral Director: After this completaly filled in by the funeral of	27. Manner of Deeth Manner of Deeth State	28f. Locatio City or	n (Street and Number of Town, State)	or Rural Route Number,	
he Hospli in 24 hour he Funera pletaly fills	29a. Certifier (Check only one) 29 Medicel Examiner: On the best of my knowledge, death occurred et the time, dat occurr				
To the To the Com	29b. Signeture end title of certifier 29c. License num	ber	29d. Dete signed (M	Aonth, Day, Year)	
XX	11/1/1 CA ymani po	1)	3/31/98		
301	30. Name and address of person who commeted cause of death (Item 23e) (Type, Print) Dominick J. Memoli, M.D. 9 Schilling Rd., Hun	nt Valley, M	id. 21031		
Stat Registra	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture				

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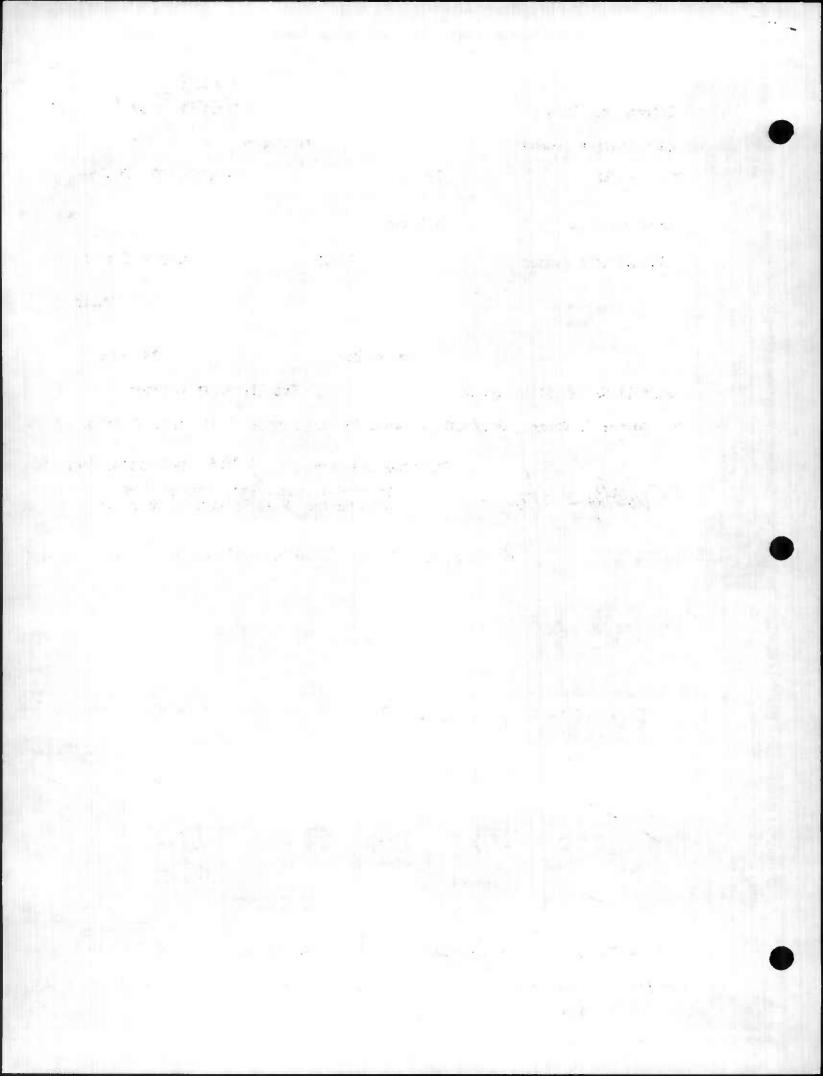
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	1. Decedent's Name (First, Midd	dle, Last)					2. Dete of D		Maria.	3. Tima of Death
Physician /Medical		noads			4b. City. Town, o	March		7.00	7:30 AM	
Examiner	4e Fecility Name (If not institution 4600 Anntana	Avenue		If Under 1 Yea	Baltimo	re	N/A			
Funeral Director	5. Social Security Number 217-46-0032 Usuai Residence of Decedent	6. Sex 1 □ M 2 🕱 F		79 Yrs.	Months Day		(Month, L	27,1918	9. Birthpi Coun Maryla	lace (State or Foreign try) and
28a-f show northed at rector	10a. Siele 10b. Count Maryland N/A	ty		City, Town or L					11	0d. inside City Limits 1 XYes 2 No
To Be Completed by Function To Be Completed by Funeral Director	10e. Street and Number 4600 Anntana 11. Marital Stalus	12. Was De	101. Zip Co 212 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Sive Year or Dates:			06	Specify Yes or Note Bican, etc.)	United		es an fndian,
	1 Never Married 2 XMa 3 Widowed 4 Divorce	irried 1 Tes						Specif		i te
	15. Decede (Specify only high Elamentary/Secondary (0-12)	ent's Education est grade completed Collega	ation completed) Collega (1-4or 5+) 16a. Decedant's Usual Occupa (Give kind of work done dilife. DO NOT use retired) Homemaker			cupation ne during most of w ired)	rorking	16b. Kind of 8	Home	dustry
		y Stickle	y, Sr.			Eva E	lizabet	h Painte	r	
	Mr. Dorsey E. 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	Rhoads, S	20b	and 46				imore, M	D 212	06
nportant ny injury nse.	4 Donetion 5 Other (21. Signature of Funeral Service	- 1	Р	2	Cemete:	dress of Facility	4/2/98			Maryland
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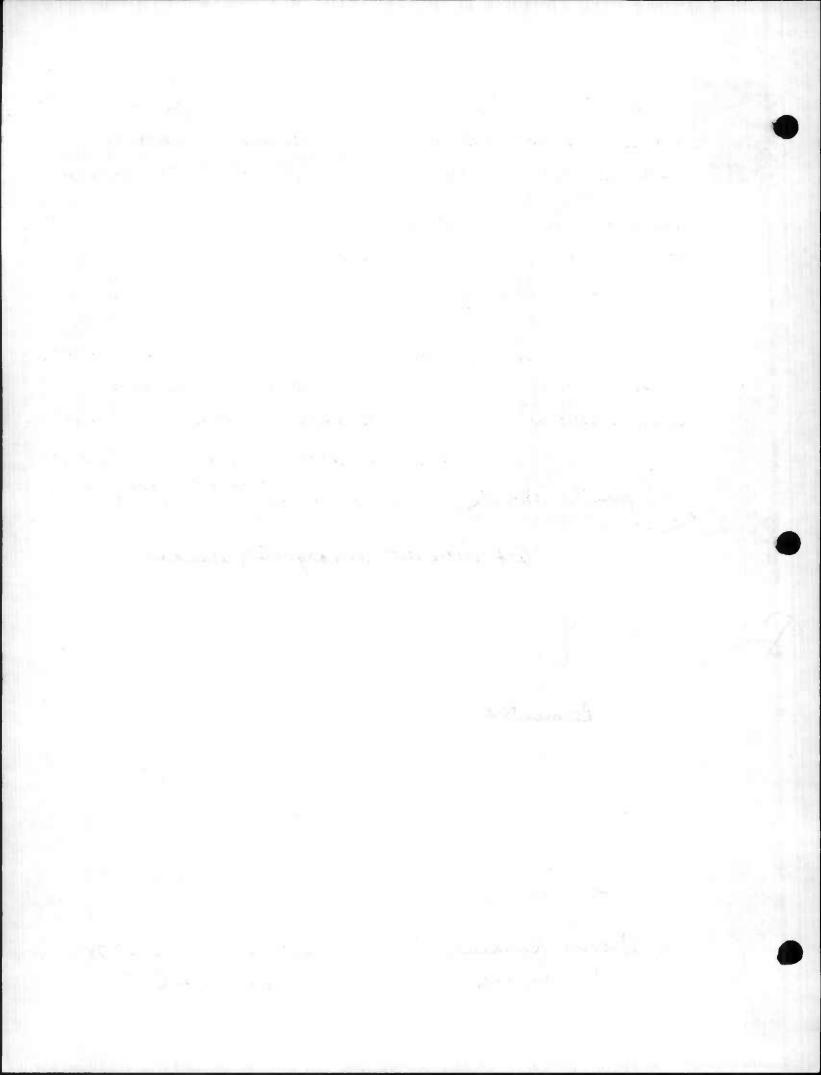
State Registrar



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State of Maryland / Department of Health and Mental Hygiene

				,	C	ertifica	ate of	Death		Reg. No.		1291
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Examine	_	4a. Facility Name (If not institution, give	e street end number)				4b. City, Town, or	Location of Dear	h 4c. County	of Death	
		CROMWELL CENTER G	ENESIS EL	DERCA	ARE			BALTIMO		BALTI	_	
Funeral Director		5. Social Security Number 214-03-1325 Usual Residence of Decedent	ex 7. A M 2□ F	ge (In yrs. 95	lest birthda Yrs	Month	ler 1 Year s Days	If Under 24 Hr Hours Mir		ey, Year)	9. Birthpla Counti MARY	ace (State or Fore y) LAND
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0		30. Name and eddress of person who	V	death (Iten	n 23a) (Typ	e, Print)	8100	y Har	2 Pom	nd		0
State	e r	31. Date filed (Month, Day, Yeer)	32. Regist			Pands 12		1 1/1/15				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name /First Middle Last) 2. Date of Deeth 98^{Year} Month 3 Willie G Roscoe 17 8:33 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Prince Georges Hospital Cheverly, MD. Prince Georges Co If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days Min. Virginia 1 M M 2 □ F 224-16-3052 76 Yrs. 4-17-21 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No MarylandPrince Georges 6200 Westchester Park, Dr. College Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6200 Westchester Park Drive 20740 S. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexicen, Prento Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Unkown Year or Dates: 1 Never Married 2 Married 1 Yes 2√ No Specity: Specif Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) District of Columbia Etamantary/Secondary (0-12) Cotiege (1-4or 5+) 3Yrs. Analyst Public School Sys. 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Benjamin Roscoe Maria Harper 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) 20785 MD Hortense Roscoe, 7278 Mahogany Dr., Landover, Hortense Roscoe, Daughter 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3-23-98, Norfolk, Virginia Calvary Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 2100 Ballentine Blvd. Part 1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina. Hale Funeral Home Norfolk, Virginia 23504 Approximata Intervat Between Onset and Death Immediate Ceuse (Finel disease or condition rasulting in daath) CARCINDMA Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initieted events resulting in death) Last BILATERAL 23b. Did tobageo use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 1 Yes 2 No 1 PYas 2 No das madical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending

The law requires that the death certificate be executed and attending physician Box 68760 BS 1 P.0. signed by t Records, certificate Division of Vital or Attending Physician: this After death. within 24 hours after deat To the Funeral Director: Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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r than "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at

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25. Was cese 1 Yas 27. Manger of Death 1 Natural 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Piace of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 (Ly Certifying Physician: To the bast of my knowledge, death occurred at the tima, date and place, and dua to tha causa(s) and manner as stated. 29s, Certifi 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s)

29b. Signi

29d. Data signed (Month, Day, Year)

Cheverly, Md.

30. Nama and addrass of person who comptated ceusa of death (ttem 23a) (Type, Print)

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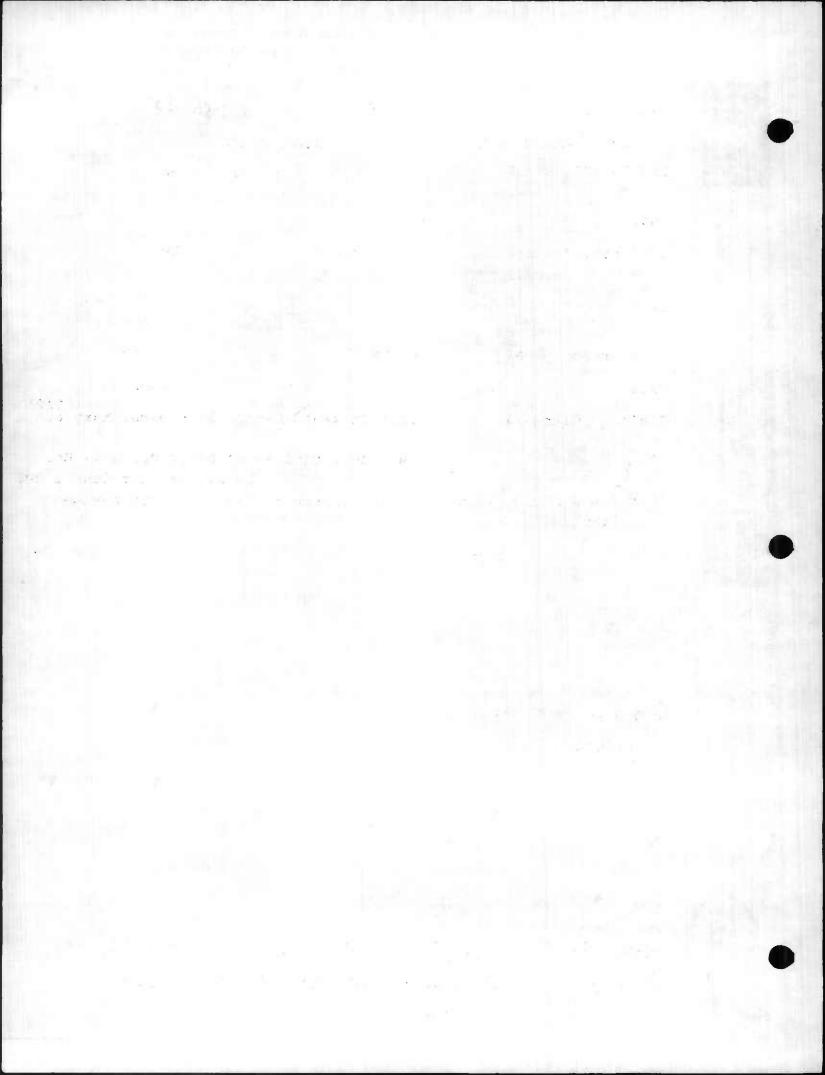
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by Funeral Director		Wes Decedent Ever in U, Armed Forces? 1 Yes 2 TNo If Yes, Give Yeer or Dates:		lent of Hispanic Origin? (Spirify Cuben, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Reco	e - American Indian, k, White, etc.	
Be Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondery (0-12) 11th Grade	tion completed) College (1-4or 5+) NA	llege (1-4or 5+)			16b. Kind of Bu	er	
	17. Fether's Name (First, Middle, Last) Oliver	alston		18. Mother's Name (First, Middle, Maiden Surname) Alma Johnson				
5	19a. Informant's Name/Reletionship (Type Isaiah Mitche	, Print)		(Street and Number or Ru		per, City or Town,	State, Zip Code) 21217, Maryland	
permit. Peges 1 and Department of Health Important: If itsm 27 eny injury or other th	20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Rer 4 □ Donation 5 □ Other (Specify)	Ce	lace of Disposition (Nan emetery, crematory or o	ther place) n. Gardens	Date 04-02-		City or Town, State dalk, Md.	
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State	30. Name end eddress of person who com Alain Benton 31. Dete filed (Month, Day, Year)		VOIFE ST	Baltimone	mo	2128	7	

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2. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARY THERESA RONEY 9:20 PM Jarci /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore City CITY Months Days Hours Min. 8. Date of Birth Months, Days Hours Min. No Month, Day, Year) 15 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 1□M 2ÅF 82 MARYZAND Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE ESSEX 1 ☐ Yes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Country? U.S.A. GEENWOOD APT. C 21221 Funeral 12. Was Decedenf Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: by Specify: WHITE 3 X Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TAILOR CLOTHING 6 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) FREDERICK VECCHIONI CARMELA LAZZARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 GLENWOOD ROAD APT.A BALTIMORE, MD 21221 JOSEPHINE CATALANO/SISTER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State GREEN MOUNT CEMETERY 4 ☐ Donation 5 ☐ Other (Specity) 3/30/98 BALTIMORE. MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MD 21224 Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or boart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy performed? of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, offica building, etc. (Specity) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number apone 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) % Maryland General Hospital M.D. Valsania 31. Date filed (Month, Day, Yeer) 32. Regisfrar's Signature

Idia Davidson

State Registrar

APR 01 1998

Funeral

Director

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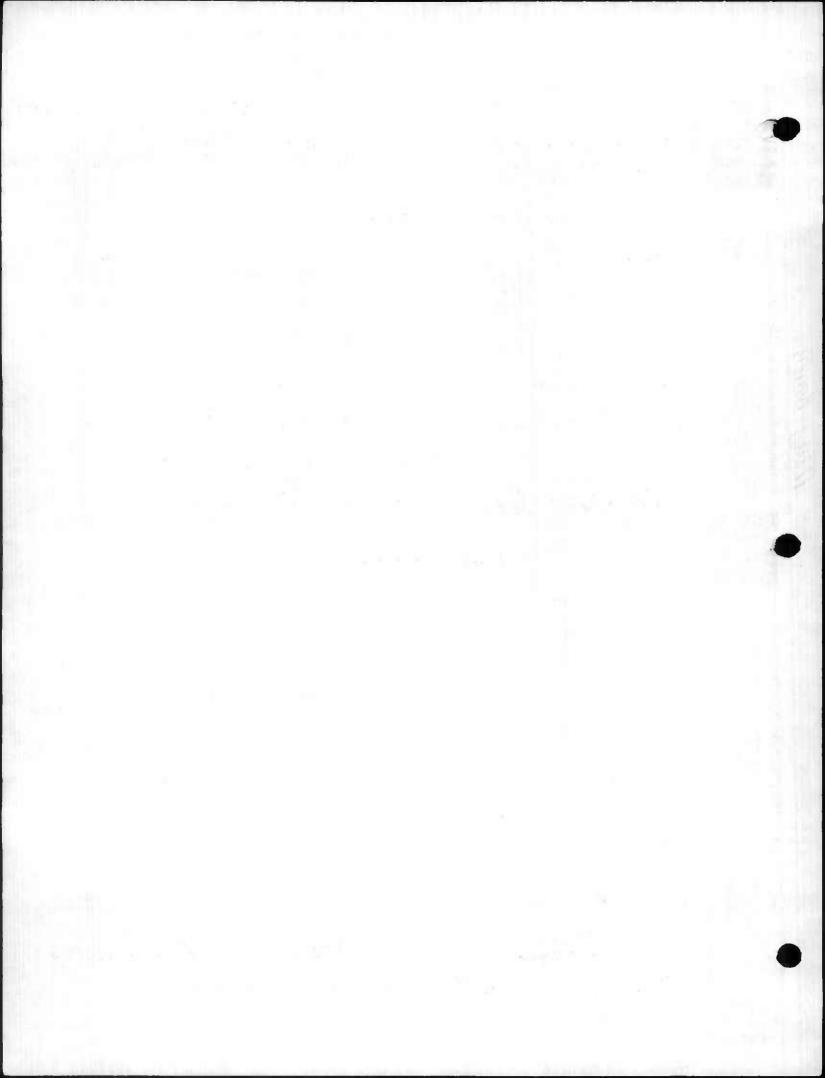
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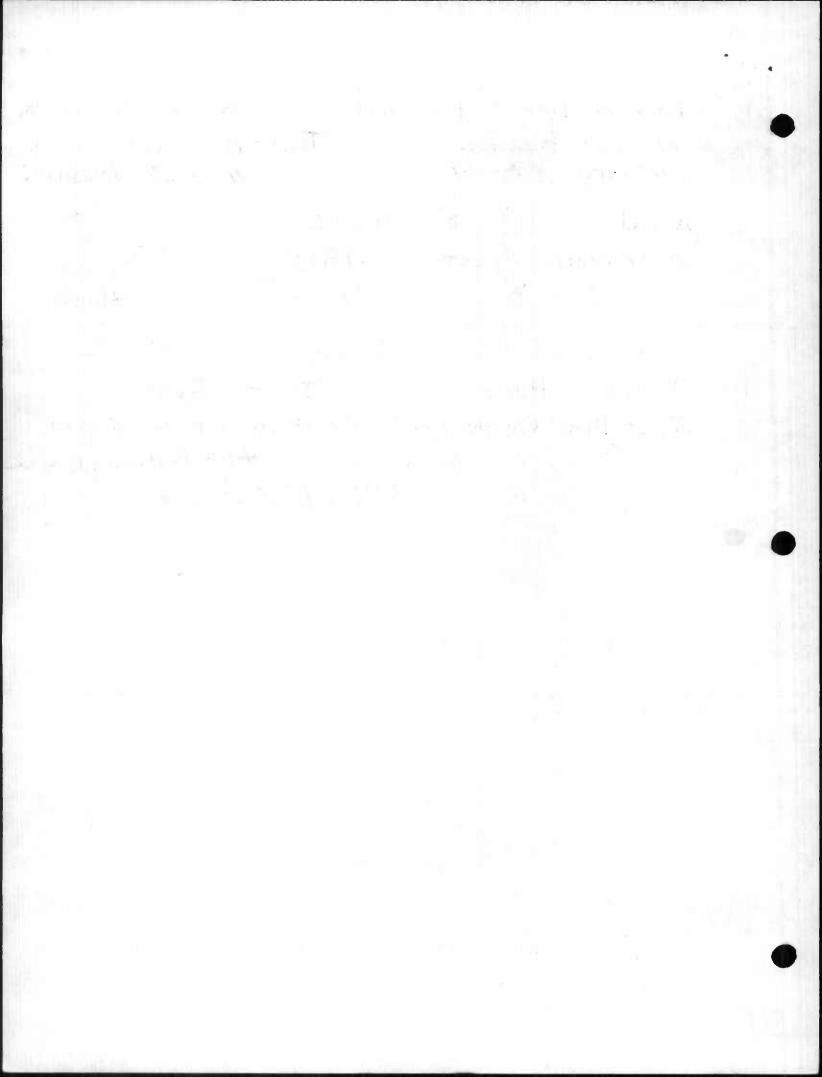
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	Physici	ian	1. Decedent's Name (First, Middle, Last)	1	2 1	1	2	2. Date of Death	Day	Year /	ima of Death
	/Medi Examir	cal	Barbara Hr 4a. Facility Neme (If not institution, give s	street end number)	Kusse	4b.	City, Town, or Loca	3 3	4c. County	98 13	1,23 PM
	Examin	iei	Gilbrest H	ospice			DIUSO	0	Bal	timore	· Count
	Funeral		5. Social Security Number 6. Sex				If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye.	ar)	9. Birthplace (S	State or Foreign
1	Director		Usual Residence of Decedent	14	7 118.			11 27	53	Man	uland
	show dat	_	10a. State 10b. County	10	Oc. City, Town or Location						side City Limits Yes 2□ No
	with the Maryia a or 28a-f show be notified at	Directo	Mary and 10e. Street and Number		Daltin	hore f. Zip Code	pate .	100	Citizen of V	What Country?	1465 2 NO
	h with		2739 Matthews	Stree	7	2121	8	100.	1.5) ,	
	ar death with the Maryia Herre 23a or 28a-f sho her must be notified at	Funeral	11. Marital Status	12. Wes Decedent Ever Armed Forces?	r in U,S. 13. Was I	ecedent of Hisp specify Cuban,	penic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)		e - American Ind	lan,
020	ors after	by	1 Never Married Amarried 3 Widowed 4 Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:	1□ Y	es 2000	Specify:		Specify	Blac	1K
21215-0020	72 ho metur dicel	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Decedent's (Give kind o	Usual Occupation	on ring most of working	16b	. Kind of Bu	usiness/Industry	
121	within she. the Me	jdmc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)			SPI	ce	,
	be filed ital Hygi of other event, I	BeC	17. Father's Name (First, Middle, Last)	1	rolo	-	8. Mother's Neme (First, Middle, Meio	fen Sumem	10)	
Maryland	2 should be and Menta is marked sumstic ev	To	Joesph +	tun+			Jawet	Tay	VOC		
Ma	の当然語	-	19a. Informant's Neme/Reietlonship (Ty)	pe, Print)	19b. Malling Ad	dress (Street en	d Number or Rural I	10	111	- 1	
e,			20a. Method of Disposition		20b. Place of Disposition cemetery, cremetory	(Neme of or other pleca)		Dete 20c	Location -	City or Town, St	ete
Saltimore,	Pag ant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)		Freen Mo	1	4	-1-98 B	alti	more 1	Margas
Ball	Depart Depart Import any inj		21. Signeture of Funeral Septice License	.6	22. Nan	ne and Address	or Facility	11			. 7
1			23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	cations that caused the	death. Do not enter the	mode of dying,	Nonth such as cardiac or	Avenue respiratory errest,	Balt	imure /	lary land
	Physician		shock, or heart failure. List only on	e cause on eech line.						Interv Onse	et Between t and Death
\mathbf{T}	/Medical Examiner		Immediate Cause (Finat disease or condition resulting in death)	Lung	Concer					14	f month
7		ner		Dde	a to (or es a consequence	e ot):					
6	tificate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions,	Due	to (or as a consequence	of ot):				Ĭ.	
8255	sician buria		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events			-					
	\$ 0 a	Medical	resulting in death) Last		to (or as a consequence	of):				 	
Box	beath cert	Physician/N	d	10							
€0	that the de ed by the a detached t	hysic	Part II. Other eignificant conditions conf	tributing to death but no	ot resulting In the underly	ing cause given	in Part I.		2 No	ntribute to the c	
S, P	es that igned to be deto	by P						1)XI Yes	20 80	3 Probably	4 Unknown
Becord Record	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	eted						24a. Wes an au performed	itopsy	24b. Were aut available completio	
(T) %	The law rate has t page 2 s	Completed						407	o Mel Ma	of death?	
	ician: The certificate rector, pag	Be Co	25. Was case referred to medical			2	26. Placa of Death (1 Yes	2 No	1 🗆 Yes	2€ No
of Vital	Physician: this certific rai director,	2	I Hes ZON NO		2 ☐ ER/Outpatient 30	DOA Other:	4 □ Nursing Home			er (Specify) H	ospice
ono	ding P. After ti	tlon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury e Work? 1 □ Ye	t 28	d. Describe how in	njury occurr	red	O .
Division	or Attendation of the death Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, street, fa			f. Location (Street City or Town, St		er or Rural Route	e Number,
ā	ttal or ins after rat Diru		4 Hottiide	building, etc. (S)	респу)			City of Town, St	a10)		
	To the Hospital or Attending Physician: within 24 hours affer death. To the Funeral Director: After this certific; completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examin	elclan: To the best of my ner: On the basis of exa and manner steted.	y knowledge, death occu imination and/or investig	rred at the time, stion, in my opin	dete and plece, and ion, death occurred	d due to the ceuse at the time, dete	ı(s) and ma end place, ı	nner as stated. and due to the ca	1 use (s)
	Within To the Compl	Me	29b. Signature and title of certifier			29c. License n	umber	29d.	Dete signed	d (Month, Day, Y	ear)
			M. Anthony,	Keley, 100	Ø	D252	las	Mo	rich	30,1990	F
			30. Name end address of person who con	mpieted cause of death	O (Item 23a) (Type, Print) N. Ch. Mes Signature Widson—Randal	Ct.	Balto in	11 2/2	20×		
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrar's	Signature	3/.	21,010.71				
0 0	Registr		APR 0 1 1998	3 Julia L	avidson-Randal	2					

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Henry F. Roese, Sr. 1998 March 4:15 PM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 3604 Galloway Road Middle River Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Yaar) | 9. Birthplece (State (Month, Day, Yaar) | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 1926 | 19 7. Age (In yrs. last birthday) Birthplece (Stata or Foraign
Country) Months 10XM 2□ F 71 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Middle River 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 3604 Galloway Road U.S.A. 21220 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. Armed Forces?

1 XYes 2 No
If Yes, Give
Yeer or Dates: WW II 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Accountant Steel Company 18. Mother's Name (First, Middle, Meiden Sumama) 17. Fether's Neme (First, Middla, Last) Emma Lange 19a. Informant's Neme/Relationship (Typa, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) (WIFE) Middle River, Md. 21220 3604 Galloway Road 20b. Plece of Disposition (Nama of cemetary, cramatory or othar place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 3/31/1998 Baltimore Co., Md. 4 ADonation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. ons that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, jouse on each line. Approximate Intervel Between Onset and Deeth LUM Canco notardate 7 morihe Due to (or es e consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours efter death v Department of Haaith and Mental Hypiena. Important: If item 27 is marked other than "natural", or flema 23a and Injury or other treumatic event, the Medical Examine manal once.

Baltimore,

Directo

Funeral

þ

Completed

with the Meryland

5. Sociel Security Number

220-12-9579

10e. Street and Number

8

Henry T. Roese

Helma Roese

20a. Method of Disposition

21.5

11. Marital Status

Usual Residence of Decedent

ettanding physician and for usa as the burial-transigned by tha e

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

edical

25. Wes cese referred to medical examiner?

1 Yes 2XNo

27. Manner of Deeth

1 XNatural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

The law requires that the death cartificate be executed been sig page 2 s certificate or Attending Physicien: director this Aftar this ithin 24 hours after death.

the Funeral Director: All mplataly filled in by the fu daath.

Division of Vital Records, P.O. Box 68760,

1941

within 2

Hospital

Registrar

Enter the diseese, or complic or heart failure. List only one Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed?

> 1 Tyes 21 No 26. Place of Death (Check only one) Hospital:

Other: 4 Nursing Home 5
Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work?

5 Pending 1 TYes 2 No investigation 6 Could not be determined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end menner es steted.

EAGERN AVE RATIMON Md 21224

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) end menner stated. (Check only one) 29b. Signeture end fittle of certifier 29c. License number 29d, Date signed (Month, Day, Year)

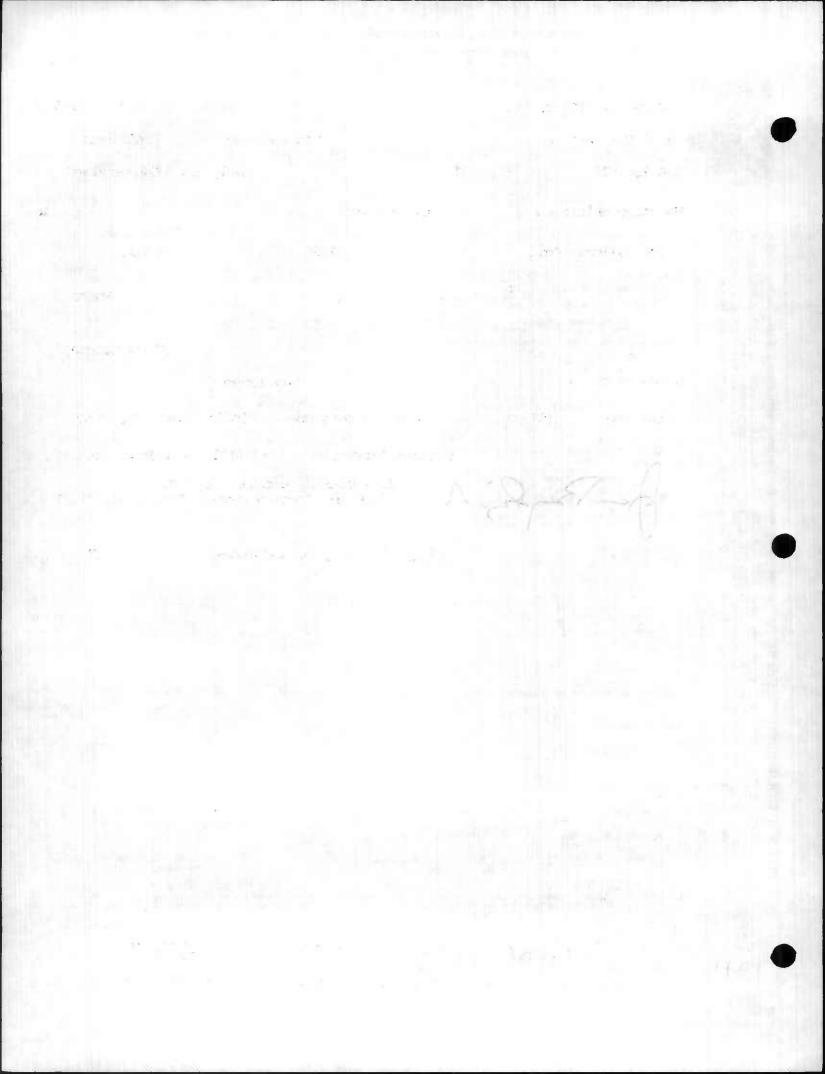
1 untell

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 4940

J4BUML

Jula Javidson Kongreso 31. Date filed (Month, Day, Yaar)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					State of	t Maryla			tment of <i>ificate of</i>	Health and <i>Death</i>	Mental Hy	rgiene		303
			1. Decedent's Nama (First		2. Data of D	eath Day	Vaar	3. Time of Death						
	Physici /Medio		NELLIE	HA	RBACK		S	WEI	TZER		Month March	1 28, 1	Yaar 998	1:12 #M
	Examin		4a. Facility Nama (If not in:	stitution, giva	street and nur	nber)				4b. City, Town, o	r Location of Dear	th 4c. County	of Death	
			Gilchrist	Cent	er					Towson		Ba1	timo	re
	Funeral Director		5. Social Sacurity Number 220-05-7291	6. Sa	ax □M 2⊠F	7. Aga (In yı 78	rs. last birtho Yr	//	If Undar 1 Yaa Months Days		1. (Month, D	rth ay, <i>Year)</i> 4, 1920	9. Birthpi Coun	laca (Stata or Foreign try) Md.
	pud *		Usual Rasidance of Daced	lant County		10c	City, Town	or Loca	tion				11	0d. Insida City Limits
	Maryla f sho	0	76.1780.	altimo			altimo						"	1 ☐ Yas 2 ☐ No
	the the	Director	10e. Street and Number	altino	re	D	altim	ore	10f. Zlp Code			10g. Citizen of V	What Coun	trv?
permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Manyland Dependent of Heelth and Mental Phylene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show enty highly or other traumatic event, the Medical Examiner must be notified at once. To Re Commisted by Filineral Director			2531 Wentwo	rth Rd					2123	4		USA	,,,,a,, 00511	,.
			11. Marital Status		12. Was Dece		U,S.	13. Wa		Hispanic Origin? (ban, Maxican, Pus	Specify Yas or N		e - Amaric	
>	or its		1 Navar Married 2[Married	Armed For	2 🔀 No			ras, specify Cu ⊇Yas 2⊠ No		rto Rican, atc.)		ck, Whita,	atc.
2	ours Frai,	d by	3 ☑ Widowed 4 □ Di	vorced	If Yas, Giv Yaar or Da	atas:		11	J Tas ZLALNO	Specify:		Specify	Whit	te
5	72 h 'natu	etec	15. De (Specify only	cedant's Edu	ucation da compiated)		16a. D	6a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businase			usinass/ind	dustry		
7	han han	Completed	Elemantary/Secondary (0-12)	Coliega (1	-4or 5+)				ed)		Comments	wi. 1	
7	Hygie ther t		1.2 17. Fathar's Nama (First, A	Aiddle I est)			Sec	cre	tary	18 Mother's N	ama /First Middle	Secreta , Maidan Suman		
0	d be i	o Be	Samue1	moora, Easty			Harba	ck		Laura	Gr		Smith	n
2	shoul mark mark	То	19a. Informant'a Name/Ra	lationship (T	vpe, Print)		19b. N	Mailing	Addrass (Stree	et and Number or I			Stata, Zip	Coda)
Ĕ	nd 2 lith a 27 is r trau		Mr. Ronald			son				Station :				
ני ע	othe othe		20a. Mathod of Disposition			20b	. Place of D	Disposit	ion (Nama of tory or other pl		Data	20c. Location -		
2	Pege ent c nt: if ry or		1 Burial 2 ☐ Cram 4 ☐ Donation 5 ☐ Of							1 Cemete:	1 1/1/9	R Long	Green	n, Md.
all	permit. Depertm Importa eny inju		21. Signatura of Funeral S	arvice Licans	sea 💮		LINIC	22.1	Nama and Add	rass of Facility			Greer	I, IId.
3	88 = 8		Supt	D	WRL					son Fune: Rd. Tow		-		
			23a. Part1. Entar tha disas shock, or haart failure	asa, or comp	ilcations that co	aused tha de	ath. Do no	t antar	tha moda of dy	ring, such as cardi	ac or raspiratory	arrest,	i	Approximete Interval Between
	Physician		onosil, or naut tandi	o. Elot only o	and bubble on a	don ma.								Onset and Death
	/Medicai Examiner	2	Immediata Causa (Finai disaasa or condition		. chi	runic	06	Str.	ective	Lung d	() case			years
	LAGIIIII	-	rasulting in daath)				(or as a co			,			I	0
1	pet lisit	Examiner			b									
	cate be executed physician and s the buriel-transit	Exar	Sequentially list conditions if any, laading to immadiat cause. Entar Undarlying Causa (Disaasa or Injury	a		Dua to	(or as a co	nsequa	ance of):				į	
,000	sicial b buri	dicai	Causa (Disaasa or Injury that initiated evants Dua to (or as a consequence of):								-			
	tificat ig phy as th		rasulting in death) Last Dua to (or as a consequence or):										100	
	death certifical attending place as t	Physician/M			d									
	he att	sici	Part II. Other significant c	onditions co	ntributing to de	ath but not r	esulting In t	ha und	erlying causa g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
	The law requires that the death certif ite hes been signed by the attending page 2 should be detached for use as	Phy									15	Yes 2 No	3 Prot	pably 4 ☐ Unknown
Ó	ras the signe	by	-										T 0.45 14/-	an automorphic disease
5	neen shoule	Completed										s an autopsy ormed?	cor	ara autopsy findings allabla prior to mplation of cause
	hes t	mpi											of c	déath?
												Yas 2 No	10	Yas 2 No
	Physician: rthis certific	o Be	25. Was casa rafarred to n axaminar?		Hospital:					ther	eath (Check only			. / /
5	£ 5 8	-	1 ☐ Yas 2 ☐ No 27. Mannar of Death		28a. Data o	of Injury	☐ ER/Outp 28b. Tin		3□ DOA 28c. Inj	4 LI Nursing	Homa 5 ☐ Ras 28d. Dascribe	how Injury occur	ar <i>(Specif</i>) red) Hospice
5	Attending For death. actor: After by the funer	ation		Panding invastigation	(Mont	h, Day Year)	Inju	ury		ork? ⊒Yas 2.⊒No				
2	Atter ector by th	Certification:	3 ☐ Suiclda 6 ☐ 6	Could not be detarmined	28a. Place	of fnjury - At	homa, farm	n, stree	t, factory, office)	28f. Location	(Street and Numb wn, State)	er or Rura	l Routa Number,
2	s after al Dir	Cert	4 D Horrida		Bullon	ig, aic. (Spe	сну)				City of Te	wii, State)		
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the funeral process.	edical	(Check only 2 Me	ertifying Phy edical Exami	ner: On the be	sls of axami	nowledga, onetion and/o	death o	ccurred et the stigetion, in my	time, data and place opinion, death occ	e, and dua to the curred at tha tima	ceusa(s) and ma , data and placa.	annar as at	ated. the cause(s)
	thin 2	Med	one) 29b. Signatura and titla of		and mann	nar statad.				nsa number		29d. Data signe		
	₹¥₽8	-	Distributed and this of	[W	V) 1.	725	, ,						
	(1)		20 Name and 11 17	MIN	my I	w	7	UVU	1)	3000		,, laron	"	0
	10		30. Nama and address of p	erson who c	G-R W	a or death (it	arry 238) (1)	ype, Pr	N. Cl	5205	Ch Ba	lto.	nd :	20215
	Sta	te	31. Data filed (Many Pay	Y (1)	32. Re	estrar's Sig	natura		•		- /			
	Registr	ar	230 11	~ 100		reme Da	4dson	Bane	2.00					

DHMH 16 Rev 6/95

3/28/98 @ 1:12 P.M.

Nellie Sweitzer

541 ET 9

Funeral

Director

ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Meryland

with 1

death

5. Sociel Security Number

246-86-6410

10a. State

Maryland

11. Marifei Status

10e. Street and Number

Directo

Funeral

by

Completed

2

Examiner

Physician/Medicai

þ

Completed

Be

2

Certification:

edicai

2

filled

completaly

Hospital within 24 hours

0

Usuei Residenca of Decedent

10b. County

8 West Randall Street

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2K Married

3 Widowed 4 Divorced

Elementery/Secondary (0-12)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

State of Maryland / Department of Health and Menta	Il Hygiene
MED C 759 1/9/09 woh Cartificate of Death	

N	ALFRED	SINCLAIR	otate of maryland, Department of Fleath and Mental							
		Items: 23 part I,27	per MEO G-758	4/8/98 re	eb <i>Certificate o</i>	f Death	Reg	. P		
	Physician /Medical			Alfred	Sinclair		2. Dete of Death Month MARCH 28	[
	Examiner		4b. City, Town, or Lo	ocation of Deeth	4					
		8 WEST RANDALL	STREET			BALTIMORE				

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates:

College (1-4or 5+)

1 Year

7. Age (In yrs. last birthday)

Yrs.

10c. City, Town or Location

6. Sex

12 M 2□ F

N/A

3. Time of Death)ey 1998 10:31 AM.

0304

4c. County of Death N/A If Under 24 Hrs. if Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) Days Hours Min Jan. 9, 1952 Louisiana

> 10d. inside City Limits X⊠Yes 2□No Baltimore City

10g. Citizen of What Country? 10f. Zip Coda 21230 United States

 Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Yes 2 No Specify: Specify White

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Construction Carpentry

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Barbara M. Sims Norman C. Sinclair, Sr.

19a. Informant's Name/Relationship (Type, Print) Wife 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen A. Sinclair Essex, Maryland 60 Moline Circle

20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3/31/1998 Towson, Maryland HIZtop Service Corp. 4 Donat ther (Specify)

Service Louis 22. Neme end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland

23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Approximate intervat Between Onset and Death

immediate Cause (Final disease or condition resulting in death) ACUTE SPONTANEOUS SUBARACHNOID HEMORRHAGE

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or es e consequença of):

Due to (or as e consequence of)

23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

NeYee 2□ No 1 Yes 2 No

MARCH 29, 1998

25. Was case referred to medicat examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospitei: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XXVes 2□ No 27. Manner of Death 1 Naturat 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of injury (Month, Day Year) 5 Pending

1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the cause(s) and manner stated. 29a. Certifier

OCME

(Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certilier 29c. License number

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

A. KORSLUM 111 Penn Street, Baltimore, Maryland 21201

4 Homicide

32. Registrar's Signature was Navidson-Handald

2 should be filed within 72 hours efter nend Mental Hygiena. Is marked other than "natural", or its Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 sh Depertment of Health end Important: If Item 27 is m eny Injury or other traum pnce.

> **Physician** /Medical **Examiner**

attending physician end I for use as the burial-transit requires that the death certificate be axecuted Box 68760. P.0. the signed by Division of Vital Records, 2 page 2 certificate has Physician: this funeral After or Attending efter deeth.

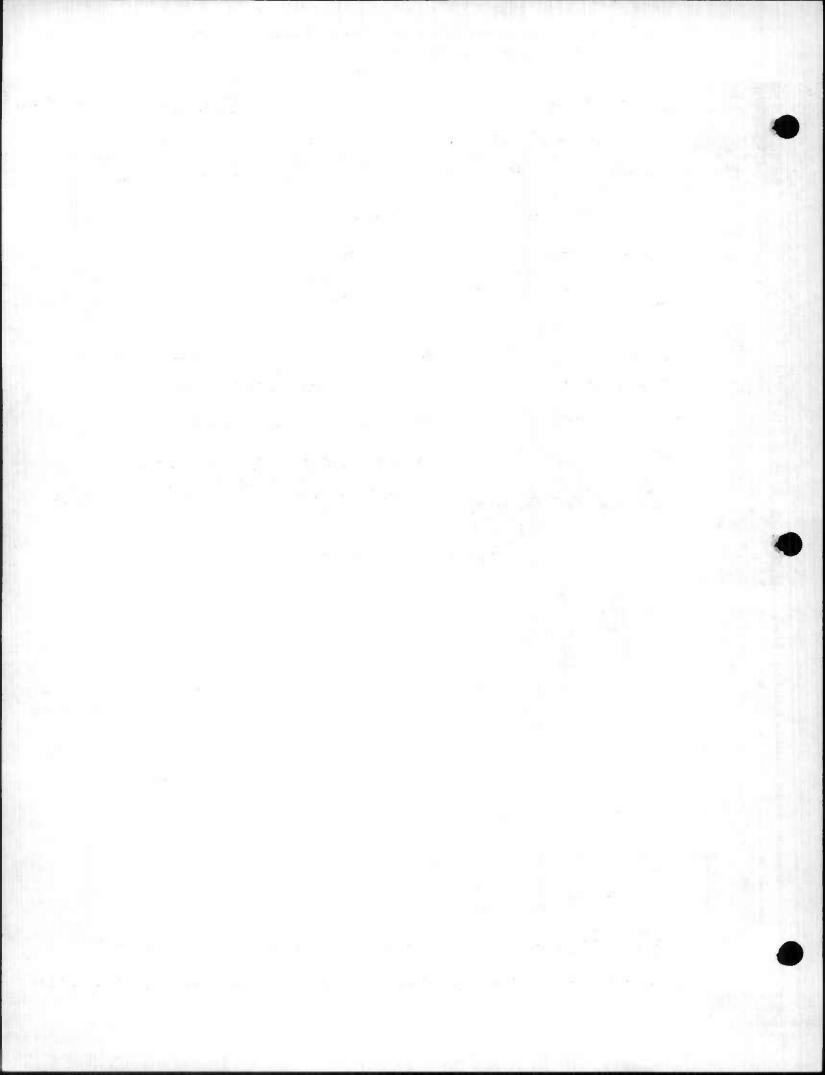
> State Registrar

ATRIA CONTRACTOR AND ADDRESS OF THE PARTY OF The state of the s 4.5 v 1 7 All the state of t Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** Scott Beulah 3:17 AM /Medicai 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hospital of Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 25F 213-20-0568 86 Yrs. Director Jan. 5, 1912 Va. Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Md. Director n/a Yes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2414 Oswego Avenue 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 21215-0020 1 ☐ Yes 25 No þ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Laborer 11th Grade Union Paper Co. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) . Peges 1 and 2 should be file ment of Health end Mentel H-lant: if item 27 is marked oth jury or other traumatic even Be Howard R. Haynie Jeannette V. Hughlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Haynie 26 Sunshine Lane Amityville, NY. 11701 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Buriai 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Special) Important: h any injury o Sepertment Md. National Cemetery April 2 Laurel, Md. 22. Name end Address of Facility Nutter Funeral Homes, Inc. 21. Signeture of Funeral Servi 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that cannot shock, or heart failure. List only one cause on a ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervei Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Myocardia Examiner Due to (or as a consequence of) the buriel-trensit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bnd Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): USB BS signed by the etter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evsliable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 hes certificate 2 DONO 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Naturel To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: Al 1 Yes 2 No 2 Accident illed in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Exsminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end manner stated. 29e. Certifier Medical (Check only one) 29b. Signatury and title of pertifier 29c. License number 29d. Dete signed (Month, Dey, Year) Resident Physician AS 2402321-RN-9492 March 28,1998 Which MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltimore, Maryland Robert Nekrich mb 2401 West Belvedere Avenue 32. Registrars Signature
Juna Dandson-Randson 31. Date filed (Month, Dey, Year) State APR 0 1 1998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month THHES SAHUEL 98 2:25 PH MARCH 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BACTIHORE HOSPITAL JOHNS MOPKINS n/a 7. Age (In yrs. last birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) 1 M 2□ F Months Days Hours 213-02-4356 Dec. 8, 1918 West Indies Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limite n/a Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 232 N. Dallas Court 21231 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes MYNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Plumber/Maintenance Man 6th grade Berea Towers 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Ivan Samuel Maude Grant 19a. Informent's Neme/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aisha Samuel 232 N. Dallas Court Baltimore, Md. 21231 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Popularia 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, Stata Mt. Zion Cemetery April 1 Lansdowne, Md. 5 Other (Specify) 22. Name and Address of Facility uneral Service Liceosee Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 rince 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final HTLU-1 LYDROMA disease or condition resulting in deeth) SEPSIS Due to (or as a consequence of): FAILURE MULTI DEGIAN 23b. Did tobacco usa contributa to the cause of death? Part II. Other elgaificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy 1 Yes 2 10 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Anpatient 2 ☐ ER/Outpatlent 3 ☐ DOA

Physician /Medical Examine

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After

deeth. Director: /

To the Hospital or within 24 hours aft.

To the Funeral Director completely filled in

director.

that the death certificate be executed

Box 68760.

Division of Vital or Attanding Physician: Examiner

Physician/Medical

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7 is marked other than "natural", or itams 23a or 28a-f show traumstic event, the Medical Examinat prust be notified at

permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "siny linjury or other traumatic event, in the say finjury or other traumatic event, in the

the Marylend

72 hours efter deeth

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

25. Was cese referred to medical

Investigation

6 Could not be

APR 0 1 1998

1 Yes 2 No 27. Manner of Death 1- Netural 5 Pending

28a. Date of Injury (Month, Dey Year)

H.9.

28c. Injury at Work? 28b. Time of 1 Yes 2 No 28d. Describe how Injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifier

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Addon

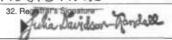
31. Date filed (Month, Day, Year)

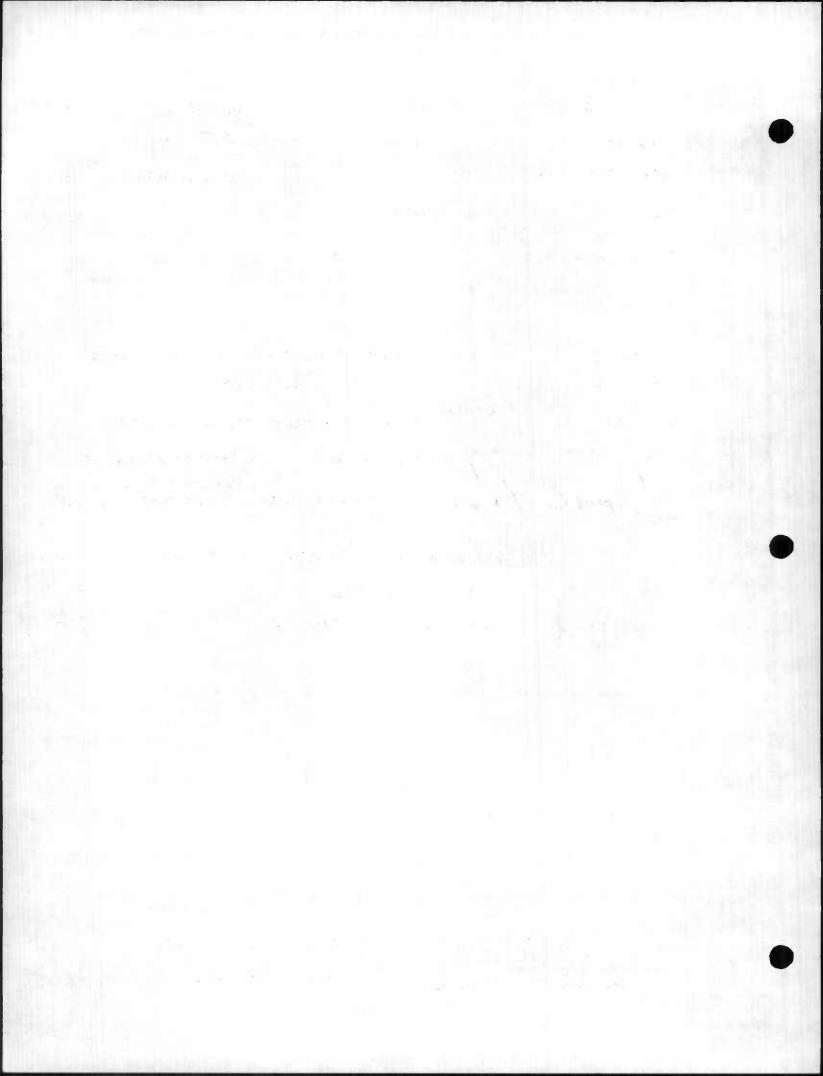
29c. License number RES OOK 29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALGORZIATA MOTTOHICE

MOHNS HOPEINS HOSPITAL 5128

State Registrar





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Suzanne 10:15 AM G. March 1998 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Center BAltimore Gilchrist TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 22 F 2980 70 Yrs. 28 Scutland Snul Usuai Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits Parkville Maryland Baltimore 1 ☐ Yes 2 Z No 10e. Straat end Number 10f. Zip Coda 10g. Citizan of What Country? 8725 21234 Stockwell Rd. Great Britain 12. Wes Decedent Evar in U,S. Armed Forcas? 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11. Maritai Status 14. Rece - Amarican Indien, Black, White, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Nevar Married 2 Married 1 ☐ Yas 2 € No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Southland Corporation Elementery/Secondery (0-12) College (1-4or 5+) Book Keeper 12 17, Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Melden Surnama) Unknown 188318 Gilmoure 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Sipple Robert 1 husband 8725 Stockwell Rd. Parkville, MD. 20b. Place of Disposition (Name of 20e. Mathod of Disposition Data 20c. Location - City or Town, Stete cematary, crematory or other place) 1 ☐ Buriel 2 Ø Cramation 3 ☐ Ramoval from State March Baltimore. Maryland Cometery 28 1998 4 ☐ Donation 5 ☐ Othar (Specify) Greenmount 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Chappl Funeral EVAMS ~ N Luny Baltimore MD. 2800 HArturd Rd. 21234 23a. Part1. Entar tha diseesa, or complications that caused tha death. Do not antar tha mode of dying, such es cardiec or raspiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disaesa or condition resulting in daeth) caranomatous meningitis all Cananoma Sequantially list conditions, if any, laading to immediata ceusa. Entar Underlying Ceuse (Diseasa or injury that initiated evants resulting in daath) Last Dua to (or es e consequença of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause givan in Part I. 23b. Did topacco use contributa to the cause of death? 1 Vee 2 No 3 Probably 4 Unknown 24e. Wes an autopsy performed? 24b. Wara eutopsy tindings avallable prior to compietion of cause of death? we 1 ☐ Yas 2 € No 1 Tyes 2 No 25. Was cese rafarred to medicel axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 1 Yas 2 No 27. Manyer of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 26d. Dascribe how injury occurred

Physiclan /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important: If Iham 27 is n any injury or other traum snos.

Physician

/Medical

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Director

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r than "natural", or hems 23s or 25s-f shor the Medical Examiner must be notified at

72 hours after

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Baltimore, Maryland 21215-0020

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Physician/Medical Examiner Completed by Be

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Vital Division of after deat Director: ò hours a 24 hours e Funeral To the P within 2 To the P

Certification: To

29b. Signature State

Medical

Ruth 31. Deta filed (Month, Day, Year) APR 0 1 1998 Registrar

1 Natural

2 ☐ Accident

3 ☐ Sulcide

29a. Certifiar (Check only one)

4 Homicida

5 Pending Invastigation

6 Could not be

30. Nama and address of person who complated ceuse of death (itam 23a) (Type, Print) Kantor MD.

4549 N. Charles

St.

1 Certifying Physician: To the best of my knowledga, death occurred at the tima, deta and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the tima, data end place, and dua to the causa(s) and mannar stated.

29c. License number

1 Yas 2 No

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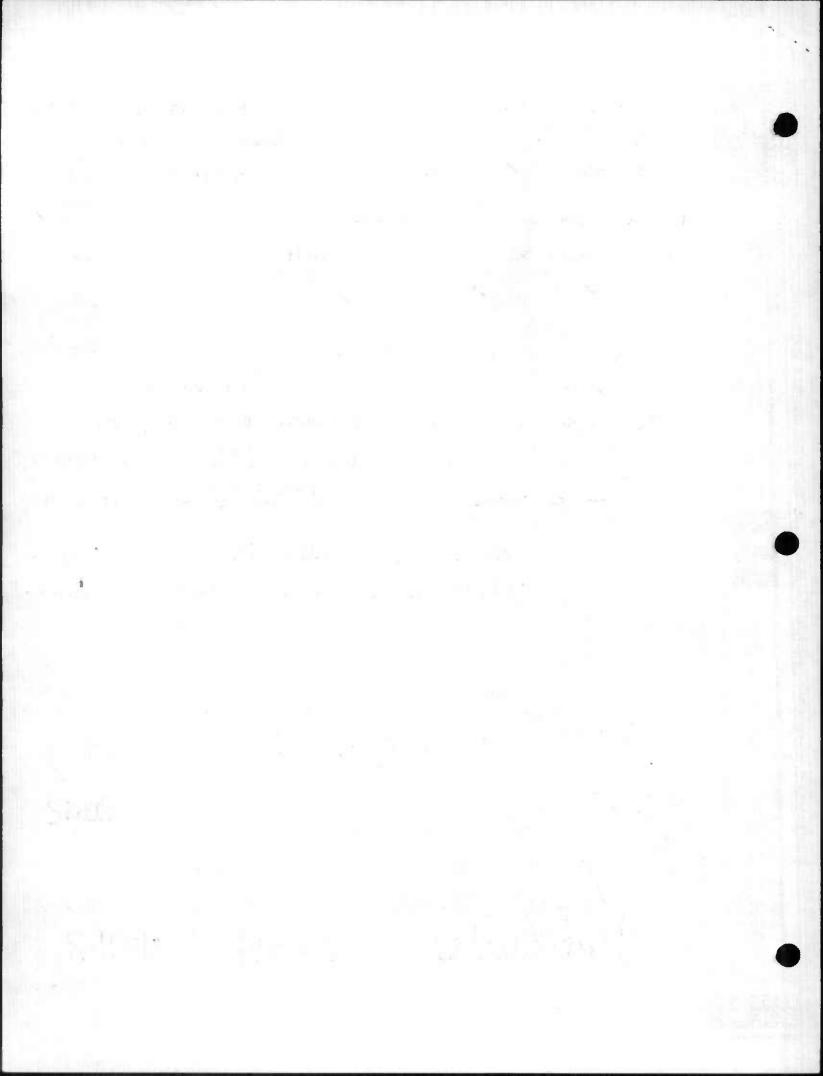
29d. Dete signed (Month, Pey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

ste_ 210 Baltimore MD

32. Registrar's Signatura hia Davidson-Randell

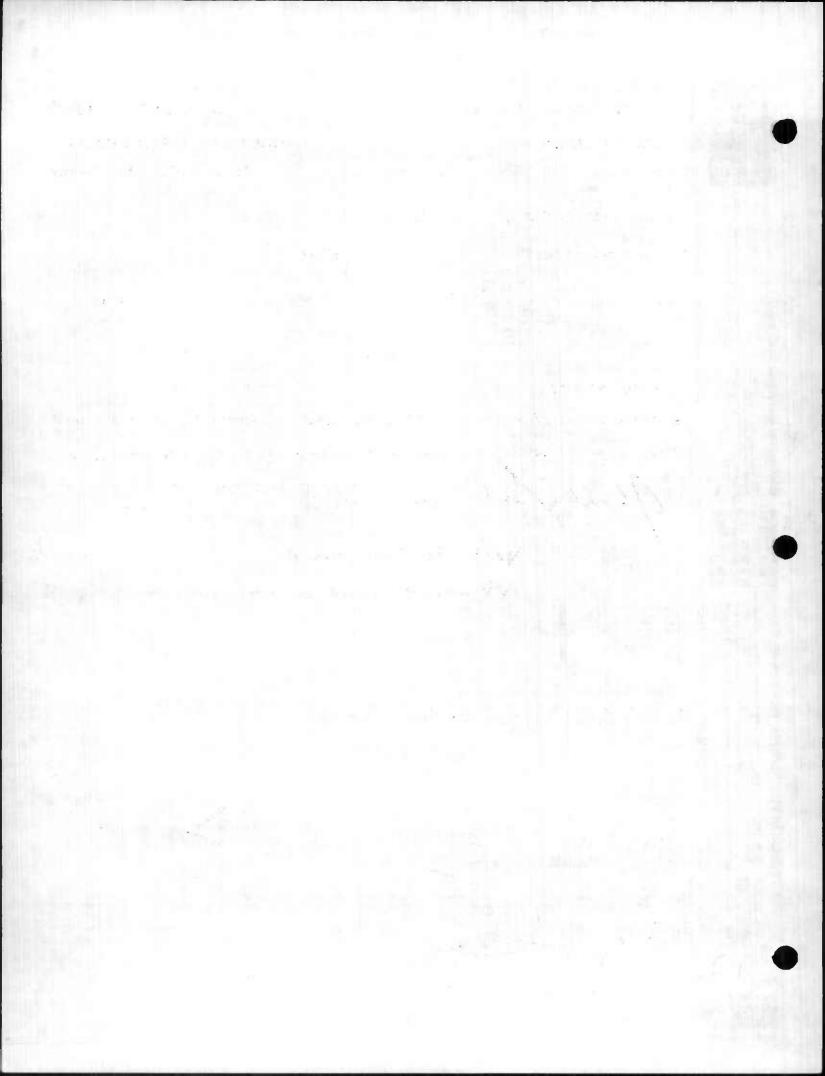
28e. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent'e Neme (First, Middle, Last) Month **Physician** March 28, 1998 Joan Rothery Soellner · /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Ellicott City 4205 Southfield Road Howard County If Under 24 Hrs. 8. Dete of Birth (Month, Dev Year) October 23,1926 If Under 1 Year 9. Birthplece (State or Foreign Country) New Jersey 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 T Deys Yrs. 145-20-3168 71 Director Usuel Residence of Decedent 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland Howard County Ellicott City 1 Yes 20 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ than "natural", or items 23s or the Medical Examiner must be 4206 Southfield Road 21042 USA Funeral 14. Rece - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 □ Specify: Specify: White à X30XWidowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) homemaker at home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 should be and Mental is marked George Rothery Julia McDevitt 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If hem 27 is m Ms. Heidi Soellner/daughter 105 Maple Street, Bergenfield, New Jersey 07621 20b. Piece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Puriel 2 Cremetion 3 Removel from State Holy Sepulchre Cemetery 3APR98 East Orange, NJ 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 Approximate Intervel Between Onset and Deeth 23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest show, or hear failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Ventricular Arrhythmin recovers Examiner Cardiovascular Disease ews trewsclewtic Examin physician end the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Box 68760. Physician/Medical Due to (or es e consequenca of): 957 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 2 No 3 Probably 4 Unknown patent ductors arterioris Division of Vital Records. PV 24b. Were eutopsy findings avellable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 1 Yes 20 No 25. Wes case reterred to medical examiner?
Yes 2□ No Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how a jury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: After t 5 Pending death. 1 Yes 2 No investigetion 2 ☐ Accident or Attended efter death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specific) 4 | Homicide 24 hours 29a. Certifier (Check only one) 1 certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 29c. License number 29d. Dete signed (Month, Dey, Year) 290. Signature and title of certified D31473 30 March 1998 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 4565 Patryce A. Toye, M.D.; Deputy M.E., Howard County Hemlock Cone Way, Ellicott City 32 Registrere Signeture

August Management Pandalle 31. Dete filed (Month, Dey, Year) APR 0 1 1998 State Maryland 21042 Registrar



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death March 30, Dev 1998 Yeer 1:30 am Joseph Sparrow 4b. City, Town, or Location of Deeth 4c. County of Death Rossville Baltimore If Under 1 Year 8. Date of Birth
(Month, Day Year)
Jan. 3,1925 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 1₩ 2□ F Months Days Hours Maryland Jan. 73 Yrs

Funeral Director

Physician

· /Medical

Examiner

Directo

Funeral

by

Completed

with the Maryland death

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic avant, the Madical Examinal must be notified at should be filed within 72 hours after Baltimore, Maryland 21215-0020 al Hygiene. permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked or any injury or o

Physician /Medical certificate be executed

Box 68760

Division of Vital Records, P.O.

attending physician and for use as the bunal-trans 888 signed by 8 peeu page 2 director, funeral s after death.

certificate

After this

or Attending Physician:

Hospital

Examiner Physician/Medical by Completed Be Certification: To 24 hours Funeral edicai completely Within 2.

Frank 4a Facility Neme (If not institution, give street end number) Franklin Square Hospital Center 5. Social Security Number 214 20 9048 Usual Residence of Decedeni 10b. County 10c. City, Town or Location Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 1126 Foxwood Lane 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Bace - American Indian 11. Meritel Status Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Buffer Monarch Rubber Co. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Lvdia Wilkenson John Sparrow 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1126 Foxwood Lane Essex, Maryland 21221 Deborah M. Claridge (Daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart of Jesus Cem 4/1/98 Baltimore, Maryland nefure of Funerel Service Licensa 22. Name end Address of Facility Bruzdzinski Funeral Home PA 1407 Old eAstern Avenue Essex, Maryland 21221 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, lick, or hear failure. List only one cause on each line. Immediate Cause (Finel Coma diseese or condition resulting in deeth) Due to (or es e consequence of) typotension Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Urosepsis Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yaa 2 ☐ No Seizure disorder Stroke, 24b. Were eutopsy findings evallabla prior to completion of cause of deeth?

25. Wes cese raferred to medical exeminer? Hospitel: 1 Yes 2 No 27. Manner of Deeth 5 Pending investigation

2 Accident 6 Could not be datarmined 3 ☐ Sulcide 4 Homlcide

29a. Certifier

28e. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

24a. Wes en eutopsy performed?

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 🕅 No

1 Cartifying Physician: To the best of my knowledga, death occurred et tha tima, data and place, end dua to tha causa(s) and manner as stated.

2 Madical Examiner: On the basis of axamination end/or invastigation, in my opinion, deeth occurred et the time, dete end place, end dua to tha causa(s) end menner stetad. (Check only one) 29b. Signature end title of certifie

29c. License number 044717

28c. Injury et Work?

29d. Date signed (Month, Day, Year) March 31, 199 8

10d. Inside City Limits

Approximate Interval Batween Onsat and Death

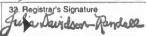
1 ☐ Yes 2 ☐ No

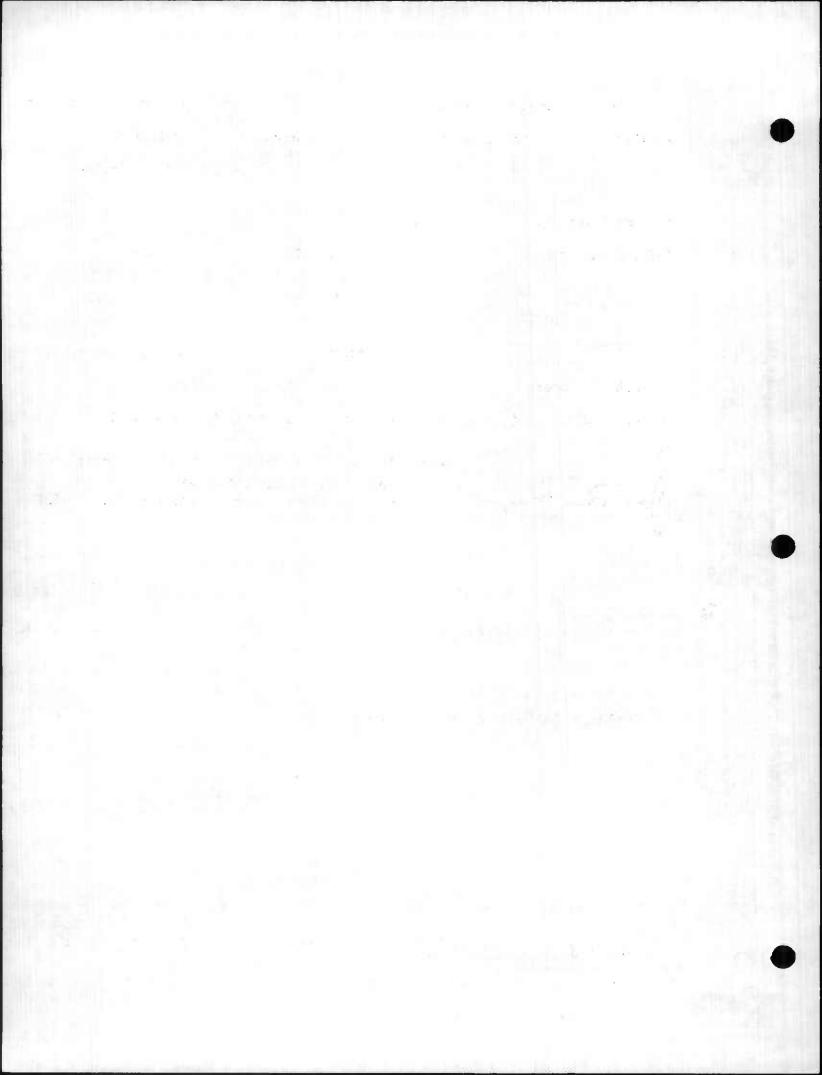
1 ☐ Yes 2 ☑ No

30. Neme and eddrass of person who completed causa of deeth (Item 23e) (Type, Print)

2112 Dundalk Avenue, Baltimore MD 21222 Carol A. Newill, MD,

State Registrar 31. Dete filed (Month, Dey, Year) APR 0 1 1998





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** 3:45 P.M. GRACE WOOD WARD

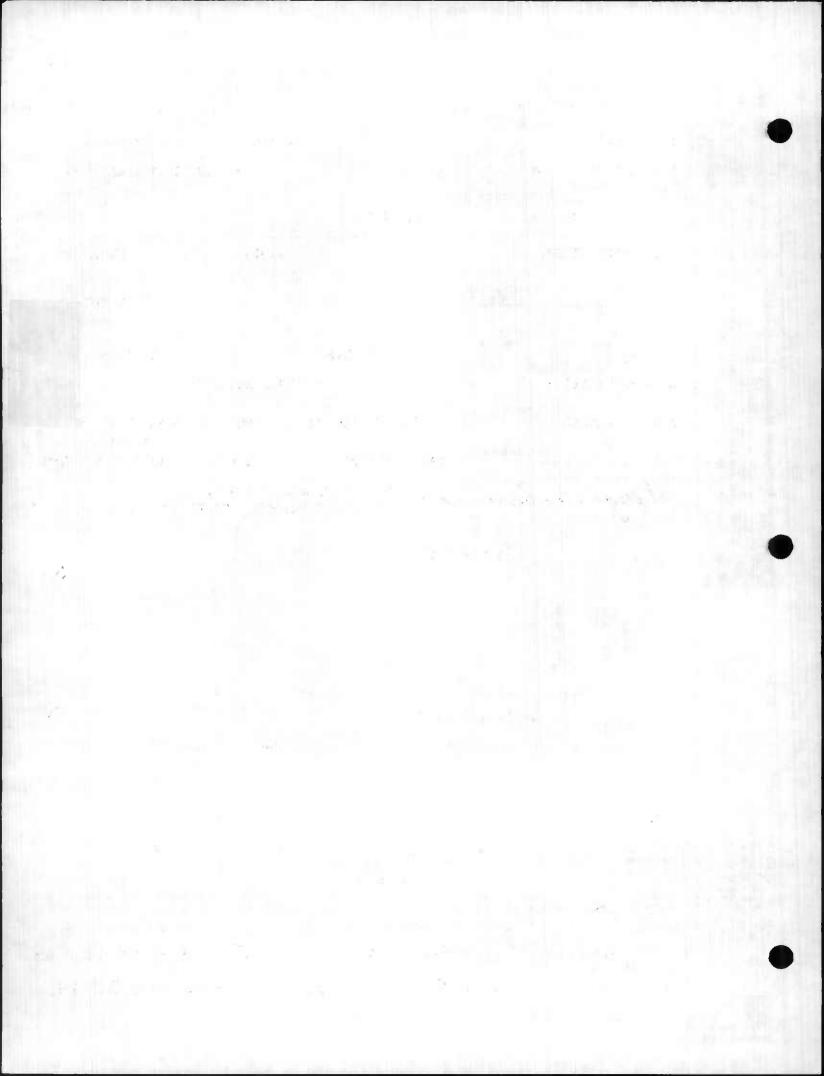
4a Facility Neme (If not institution, give street and number) 1998 MARCH * /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A MERLY MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthpiace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2□F Months Deys 74 Yrs. 217-12-630 Maryland Director DECEMBER 28, 1923 Usuel Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumetic event, the Modical Examiner must be notified at 1 Yes 2 No Baltimore City Directo N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 1025 South Curley Street Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Meritel Status Bleck, White, etc. permit. Pages 1 end 2 should be filled within 72 hours effer to Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural" any Injury or other traumatic events. 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16h Kind of Business/Industry during most of working (Give kind of work done di life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Finance 12 Years Clerical 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Percy Winfield Galbraith Grace Bernadette Hall 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) Nancy A. Rachuba 2704 Dillon Str. Daughter Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 4/2/1998 Dundalk, Maryland 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of 7922 Wise Ave. Dundalk, Maryland Pert1. Enter the disease, or complications that caused is death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) · PULMONARY EMBOLISM Examiner Examiner ACIDO515 physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): requires that the death certificate be exec P.O. Box 68760. Physician/Medical Due to (or es a consequence of): 80 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA Division of Vital Records. by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 has 1 Yes 2 No certificate 1 ☐ Yes 2 R No or Attending Physician: director, 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitat: 1 ♣Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No After this funaral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Naturei 5 Pending 24 hours efter deeth. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 🌿 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the cause(s) end menner as steted. edical completely (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) end manner stated. within 2 the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P11194 C. Danlen Fran, 110. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTI MORE MD DANUHAUSEN-BRUN. MERCY MEDICAL CENTER CHRISTIAN M.D. 31. Dete filed (Month, Dey, Year) 32. Registrer Signeture

Q Julia Davidson-Randalle State APR 01 1998 >

DHMH 16 Rev 6/95

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xaminer			f not Instituti LOT DE		street and n	rum ber)				4	BEL		cation of Dea	th 4c. C	County of	Death	D
neral ector	5. Social S		umber	6. Se		7. Age	(in yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Undar Hours	24 Hrs	8. Date of Bi (Month, D SEPT . 2	irth (193			ica (Stata or Foreign
rector	Usual Res		10b. Count	ity		1	10c. City, 7	Town or Lo	cation							10	d. Inside City Limits
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Funeral Director	10e. Stree 512		nber LOT DE	RIVE		î			10f. Zip	Code	2	1015		10g. Citize		U.S.	
by		ever Marrie	ed 2 Ma		12. Was De Armed F 1 Tes If Yas, G Year or	Forces? 2 No Sive			Was Deced if Yas, spec 1 ☐ Yes	cify Cuba	ispanic Orl n, Maxican Specify:	gin? (Spe i, Puerto I	cify Yas or N Rican, etc.)		Black	- America , White, e	tc.
To Be Completed	Element		15. Decede ify only high ndary (0-12)	nest grad	de completed	d) (1-4or 5+)		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us EREC	rk done d se retired	ation Juring most	t of workli	ng		d of Bus	oiness/Indu	ustry
o Be C			First, Middle										(First, Middle SHBOCK	a, Maiden S			
ver traum		9a. Informant's Name/Relationship (Type, Print) FRANCES HARRIS						19b. Mailing Address (Street and Numb									
		FRANCES HARRIS a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State						512 CAMELOT DRIVE 20b. Placa of Disposition (Name of						MARY		210°	
	1 ₹ B	Burial 2				n State	cem	etery, cren	natory or o	other plac		4	Date /1/98				ARYLAND
an	23a. Part shoo	1. Enter th	ne disease, rt failura. Li	or comp	olications that	caused th	no donth	-04	644-E	ASTE.	VIV. AV	BUMLIE.	BALTI	TMOKE:	, MA	KATA	ND 21224-
ledical Examiner	Immediate disease or resulting in Sequentla if any, lea cause. Er Cause (Dithat initiate resulting in	e Cause (in condition death) ally list conding to implement under the condition of the con	Final nditions, mediate rlying injury	{		5 U	ue to (or e		quence of):	;	g, such es	cardiac o	r respiretory	errest,			ND 21224 Approximate Interval Between Onset and Death
edical Examiner	Sequentla if any, lea cause (Di that initiat resulting in	e Cause (i ir condition in death) ally list conding to im ther Under isease or i ed events in death) L	Final nditions, mediate trying injury	{	bd.	D D D d death but	ue to (or es	s a consects a consects s e consects a consects of the consect	quence of):				23b. Dic	d tobacco u	ies conf	tribute to	the cause of death?
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Completed by Physician/Medical Examiner	Sequentla if any, lea cause. Er Cause (Di that initiat resulting in	e Cause (in condition death) ally list condition in the Under Under Under isease or led events in death) L	Final nditions, mediate riying injuryast	{	bd.	D D D d death but	ue to (or es	s a consects a consects s e consects a consects of the consect	quence of):		en in Part I		23b. Dic 1 [24a. Wa par	d tobacco u Yea 2 s an autops formed?	isa conf	tribute to 3 Proba 24b. Watawa	the cause of death? ably **Unknown re autopsy findings liable prior to noletion of cause
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pletery filled in by the funeral director, page 2 should be detached for use as the burist-transit and edical Certification: To Be Completed by Physician/Medical Examiner	Sequentla if any, lea cause. Er Cause (Di that initiate resulting in 1972) 25. Was cexamin 1974 27. Manne 1974 27. Manne 1974 29a. Certif (Checone)	e Cause (if recondition in death) ally list cording to im the funder is ease or lead events in death) L her significant in the funder is ease referriner? as 2	Final nonditions, mediate riying injury ast icant conditions of the conditions of th	tiona co	b. c. d. hontributing to a particular of the public of	Do Do Do Do Do Do Do Do Do Do Do Do Do D	ue to (or exue to (or exue to (or exue to (or exue to (or exue to (or exue))) 2 □ EF Year) 26 Y - At homm (Specify) my knowle xamination	s a consect s a co	quence of): quence	DA Oth DA Oth Post Injur Wor 1 y, office et the tim, in my o	26. Placeer: 4 Nevy at Array Array Array Array an umber	e of Death	23b. Dio 1 24a. Wa pari 1 (Check only ne 5 A Res 28d. Describe 28f. Location City or To	d tobacco u Yea 2 Is an autops formed? Yes 2 Yes 2 (Straet and own, State) e cause(s) a b, date end p 29d. Data	Other occurred Number and man plece, as a signed	tribute to 3 Probi 24b. War avai corr of d 1 C r (Specify, ed)	the cause of death? ably Unknown re autopsy findings liable prior to noletion of cause eath? Yes 217No Pouta Number, ated. the cause(s)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer KICHARD 4c. County of Deeth 10:30 A.r PARCH NOKOL 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) HARFORD 822 DELRAY ORIV 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 5. Sociei Security Number 7. Age (In yrs. lest birthdey) Deys 128 M 2□ F Months KENDET Yrs. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No HARFORD FOREST DARALARO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? DRIVE DILRAY . 9 822 21020 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes ZN No
If Yes, Give
Year or Detes: ... Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Meritel Status Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 13485 2485. SALLSMAN DENTAL 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) KICHARD LEVAH POOLL 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) FORWT HILLI BRYLAND 832 OIRAY DRIVE SIATAS E BOWSER Date MARCH 31 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 18 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1008 BULAIR AiR 1 (ARYLAND MORIAL 21. Signiffun of Funerei Service Licensee EVAN FUNERE CHAPIL-BILRIR, P.A. 22. Name end Address of Fecility 23a. Pert1. Enter the disease, or complications that saused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. MARYLAND Immediate Ceuse (Finel diseese or condition resulting in deeth) vascular Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury fhat Initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown dependent 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Obstructive pulmonary VITENE 250 No 1 T Yes 2 No Chronic 1 Yes 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ≅ Residence 6 ☐ Other (Specify) Hospitel: 1 Yes 2 No 1 | Inpatienf 2 | ER/Outpetient 3 | DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

r 28a-f show show

s marked other than "natural", or items 23a or numatic event, the Mod cal Examiner must be

Directo

Funeral

by

Completed

Be

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Health a

Department of Important: If it any injury or o

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medical 88 USB signed by the a þ Completed Be

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, certificate has lirector, page 2 s or Attending Physician: director, this After Director within 24 hours after d To the Funeral Direct completely filled in by

Certification: To

edical

29b. Signeture and title of certifier

5 Pending

investigation

6 Could not be determined

27. Menner of Deeth

122Neturel

2 Accident

3 Sulcide

29a. Certifier

4 | Homicide

(Check only one)

28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Pleca of Injury - Af home, ferm, street, fectory, office building, etc. (Specify)

29c. Licanse number 038933

28c. injury et Work?

1 Yes

2 No

Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piaca, and due to the cause(s) end menner stafed. 29d. Date signed (Month, Day, Year)

MARCH 30, 1998

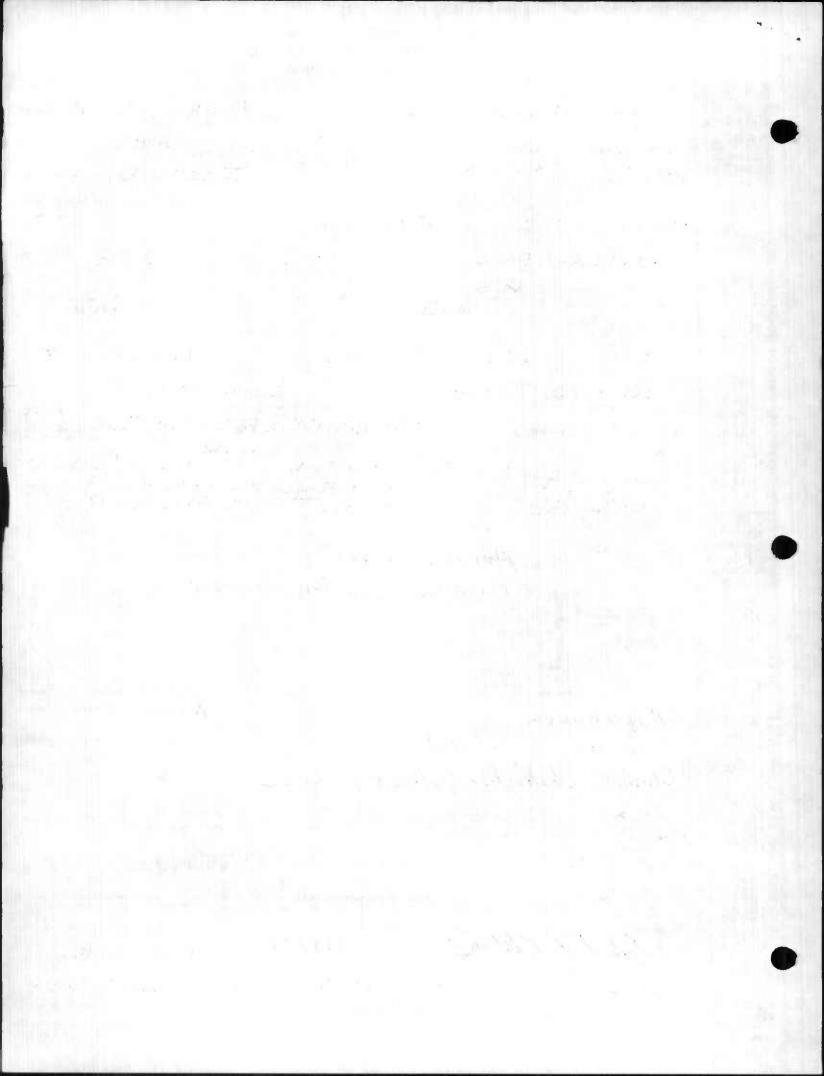
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

104 Phymires ROAD BULAIR MARYLAND 40 32. Registrar's Speature 31. Dete filed (Month, Dey, Year) APR 01

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth Month MARCH 30 1998 04:00 AM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday)

29 Yrs. If Under 1 Year Birthpiaca (State or Foraign
Country) 5. Social Sacurity Number Days 125M 2□ F 212-16-5025 Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? d10 Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yas 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 20 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) machinise 10 YES 17. Fathar's Name (First, Middle, Last) 19e. informent's Neme/Relationship (Type, Print) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulane 21. Signature of Funerel Servica Licansae hapel of Maryland 21093 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdlac or shock, or heart feilure. List only one cause on each line. immediate Cause (Final disease or condition resulting In death) Cordeouxcular Due to (or es a consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of) Part il. Other significant conditiona contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Wera autopsy findings available prior to completion of ceuse of deeth? 2 HNo 1 Yes 2 No 25. Was case referred to medical exeminer? 28. Piece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

Department of Haalth e Important: If Itam 27 Is any Injury or other tra once. of Haalth

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

ò 238

Herns

natural, or

1 end 2 should be filed within 7 Haalth end Mentel Hyglena. am 27 Is marked other than °r

Baitimore, Maryland 21215-0020

Vingling,

Director

Funerai

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Completed

Be 10

physician end the buriel-transit the death certificete be axecuted

Box 68760

P.O.

Division of Vitai Records.

Examiner Physician/Medicai þ Completed Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, I Be Certification: To

27. Menner of Deeth 1 Neturel

2 Accident 3 Sulcide

4 - Homicide

29e. Certifier

State Registrar

cai

2 Msdical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end menner stated. 29b. Signature end title of certifier

5 Pending invastigation

6 Could not be

APR 0 1 1998

29c. Licensa number 19166

28c. injury et Work?

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who Daydon Randell

29d. Date signed (Month, Dey, Year)

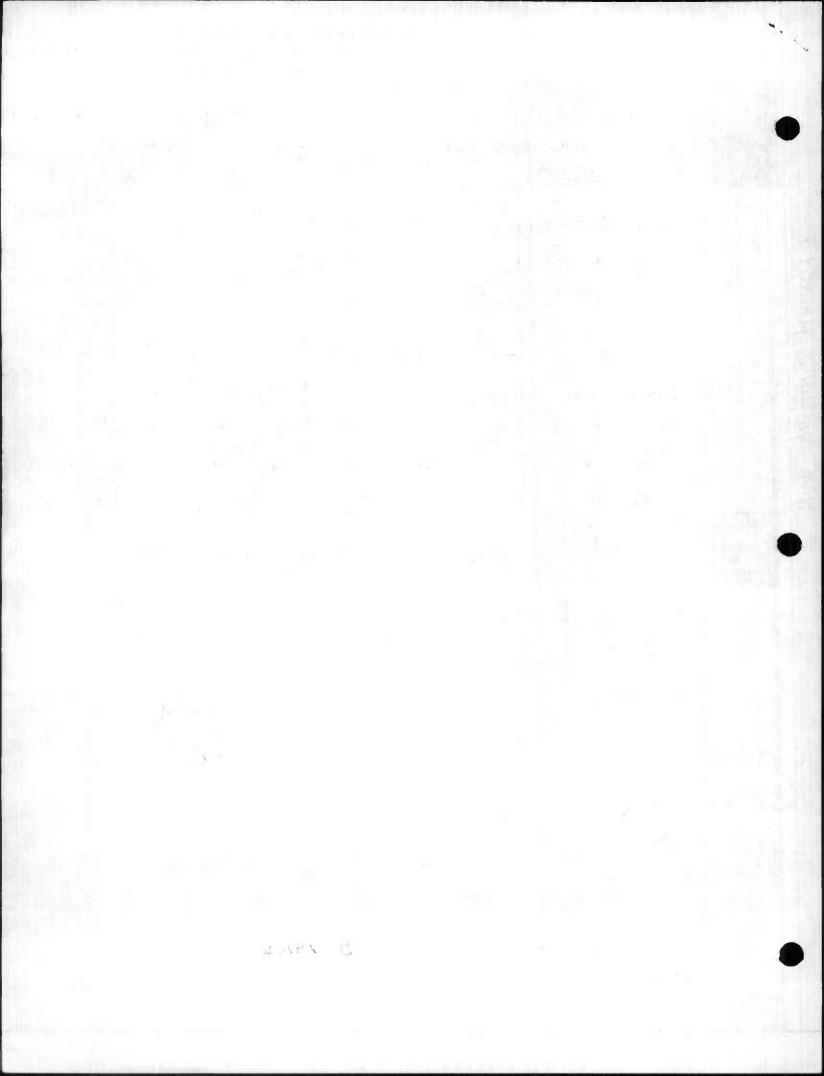
28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

lock Rd Cockeysville, Md 21030 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

To the Hospital within 24 hours a To the Funeral Completely filled



State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. I	9 B	10	314	
	Physic	an	Decedant's Name (First, Middla, La	st)					2. Data of Do Month		Day	Yeer	3. Tima of De	
	/Medi		Kenneth	Ray Amo	oss				March	16,	1998	3	7:4	OPM
	Exami		4a. Facility Nema (If not institution, giv	re street and number)				4b. City, Town, or	Location of Dea	th	4c. County	of Death		
			8800 Gue Road					Damascus	3	-	Mont	gome	ry	
	Funeral Director		5. Social Security Number 6. S 212–40–6961	Of the second	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Deys			rth ay, Yea	940	9. Birthp Cour Mary	place (State or Fi land	oraign
	and		10a. Stata 10b. County		10c. City, T	own or Loca	ntion			_		1	Od. Inside City I	Limits
	he Mary	ector	Maryland Montgome	ery	Dam	ascus							1 ☐ Yas 2	No No
	ath with t	Funeral Director	10e. Street and Number 8800 Gue Road				10f. Zip Coda 20872				Citizan of \ Ameri	can		
21215-0020	72 hours efter death with the Maryland "natural", or items 23a or 28a-f show dost Examiner must be notified at	Completed by Fune	11. Maritel Status 1 □ Nevar Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yes 2 ☑ N If Yas, Giva Yaar or Datas:			as Dacedant of I ras, specify Cub ☐ Yas 2점 No	Hispanic Orlgin? (Sean, Maxican, Puer Specify:	Specify Yas or No to Rican, atc.)	0-	Blac	e - Americ ck, Whita, /: Whi		
5-0	72 h netu	tec	15. Decedent's Ed (Spacify only highast gra		1	6a. Deceda	nt's Usual Occu	pation during most of wo	nkina	16b.	Kind of B	usiness/in	Justry	
21	C 3	D C	Elementery/Secondary (0-12)	College (1-4or 5-	+)	lifa. Do	O NOT usa retire	id)	9	Tr	caffi	c Sig	na1s	
		S	12			Inst	aller							
Pu	0 0 0	Be	17. Father's Name (First, Middla, Last,	_					ma (First, Middle					
Xa	should be ind Mental I	2	Stanley A. Amo					Clara	India	Si	nowde	n		
, Maryland	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Alma Lou Amoss -			_		and Number or R d, Damas				Stata, Zip 20872		
ore			20a. Mathod of Disposition		20b. Place	e of Disposi	tion (Nama of tory or other pla	ica)	Data	20c. Location - City or Town, Stata			wn, Stata	
Baltimore,	permit. Peges Department of I Important: If ite any injury or o		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					atorium	3/17/98	8 Alexandri		dria.	Virgin	nia
alti	pemit. Pege Department important: If any injury or once.		21. Signature of Funaral Serviça Licar	nsee		22.	Nama end Addre	ess of Fecility		-				
m	Ded in g		OU Pa	Molernoth				lesworth						
			23e. Pert1. Entar tha disaasa, or com shock, or haart feilure. List only	distinct that caused	Ol Ride	e Road,	Damasc	us,	Mary	land	20872 Approximate			
	Physician /Medical Examiner	Immediete Ceusa (F disaasa or condition rasulting in daath)	Immediate Causa (Final disaasa or condition rasulting in daath)	a. Myoc	ARC Dua to (or as			NFAI	RCTI	0	N		ACU 7	
0,	rificete be executed ng physician and es the buriel-transit	Exami	Saquantially llst conditions, if any, laading to Immadiata cause. Enter Undartying Cause (Diseese or Injury that initiated avants	b	Dua to (or as	a consequ	ance of):							
x 68760,		Physician/Medical	that initiated avants rasulting in daath) Last	d	Dua to (or as	a consequa	ance of):							
Вох	eath cer ettendir for use	ian										1		
P.O.	thet the de ed by the e		Part II. Other algnificant conditions of	ontributing to death bu	t not resultin	g in the und	arlying causa gi	van in Part i.	23b. Did tobacco use contribute					
Records,	The law requires thet the death ce ste has been signed by the ettendi page 2 should be detached for use	Completed by							24a. Was	s an au ormed	itopsy ?	ev	ara autopsy find ellabla prior to impletion of caus daath?	
	The la	Ю							10	Yes	250 No	1[∃Yes 2□ No)
ia		Be	25. Wes casa referred to medical					26. Placa of De	ath (Check only	ona)				
>		0	axaminar? 1☑Ves 2□ No	Hospital:	nt 2 ER	/Outpatient	3 DOA	har: 4 Nursing I	Home 5 Ras	idanca	6 □Oth	ar (Specif	(y)	
0		L :	27. Menner of Death	28e. Data of Injury	28	b. Tima of	28c. Inju Wo		28d. Dascribe				,,	
0	tending Ph leath. tor: After th the funeral	atio	Natural 5 ☐ Panding invastigation	(Month, Day	raar)	injury		Yas 2□No						
Division of Vital		Certification:	3 Suicida 6 Could not be datarmined	28a. Place of Inju- building, atc.	, farm, strae	it, factory, offica		28f. Location City or To			per or Flure	al Routa Number	r,	
	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f	edical C			axemInation	wledga, daath occurred at tha time, date and place, and duation end/or investigation, in my opinion, deeth occurred at th								
	To the within 2 To the comple	Me	29b. Signetura end titla of continue	0/		a. Licen	se number	T	29d. Deta signed (Month, Day, Year)					
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			20 Named Tille	each						L		, -,		-
			30. Name end addrass of person who Francis C. Mayle	e, M.D. 10)215 F	'ernwo	od Road	- Suite	301, Be	the	sda,	Mary	land 20	817
	Sta		31. Data filed (Month, Day, Year)	32. Registra	-									
	Registi	ar	*/ \Q 1 8 19t	38 Alia	Mucho	Real	l.							
DH	MH 16 Rav 6/9	5	2 0 100	U		VQA	-1							



driver

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 11:15 am **ELMER** BARNES LAWRENCE 1998 March 20

4b. City, Town, or Location of Death

Cambridge

Physician /Medicai

Examiner

physician end s the buriel-trans

USB 85 ettending |

signed by

certificate hes been si irector, page 2 should i

lal or Attanding Physician: T is effer death. In Director: After this certificat ed in by the funeral director, p

To the Hospital o within 24 hours of To the Funeral DI completely filled in

The lew requires that the deeth certificate be executed

Records, P.O. Box 68760,

Division of Vital

Examiner

Physician/Medical

Completed by

Be

10

Medical

4a. Facility Neme (If not institution, give street and number) 511 Goldsborough Ave. 5. Social Security Number 214-07-9825 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location Cambridge MD Dorchester 10e. Street and Number 511 Goldsborough Ave. 12. Was Decedent Ever In U.S. Armed Forces?

12. Was Decedent Ever In U.S. Armed Forces?

12. Was Decedent Ever In U.S. Armed Forces?

13. Was Decedent Ever In U.S. Armed Forces?

14. Was Decedent Ever In U.S. Armed Forces?

15. Was Decedent Ever In U.S. Armed Forces?

16. Was Decedent Ever In U.S. Armed Forces?

16. Was Decedent Ever In U.S. Armed Forces?

17. Was Decedent Ever In U.S. Armed Forces?

17. Was Decedent Ever In U.S. Armed Forces? 11. Marital Status 1 Never Merried 2 Married by WW II 3 ☑ Widowed 4 □ Divorced Completed 15. Decadent's Education

10f. Zip Code 10g. Citizen of What Country? 21613 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2LINO Specify: Specify: white 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

4c. County of Death Dorchester

state hospital

20c. Location - City or Town, State

Cambridge, Maryland

9. Birthplace (State or Foreign

10d. Inside City Limits

1/2 Yes 2 No

Mary Pand

Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Vernon Barnes

18. Mother's Name (First, Middle, Maiden Surname)
Flora Creighton

19a. Informant's Name/Relationship (Type, Print) Lawrence E. Barner, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 65, Woolford MD 21677

4 □ Donation 5 □ Other (Specify) Dorchester Memorial Park 3-23 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the court. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Fecility
Thomas Funeral Home PA 700 Locust St. Cambridge, MD 21613

Immediate Cause (Final disease or condition resulting in death)

moning

Approximete Interval Betweer Onset and Deeth

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last

Due to (or as a consequence of): Due to (or as a consequenca of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 16 Yes 2 No 3 Probably 4 Unknown

COPD

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

24b. Were autopsy findings eveileble prior to 24e. Wes en autopsy

25. Was cese referred to medical examiner? 1 Yes 20 No

6 Could not be determined

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA

completion of ceuse of death? 1 Yes 2 No

27. Manner of Death 1 Watural 1 Natural 2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending Investigation

Hospital:

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 🗆 Yes

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and the of certifier

mp,

29c. License number

29d. Date signed (Month, Day, Year)

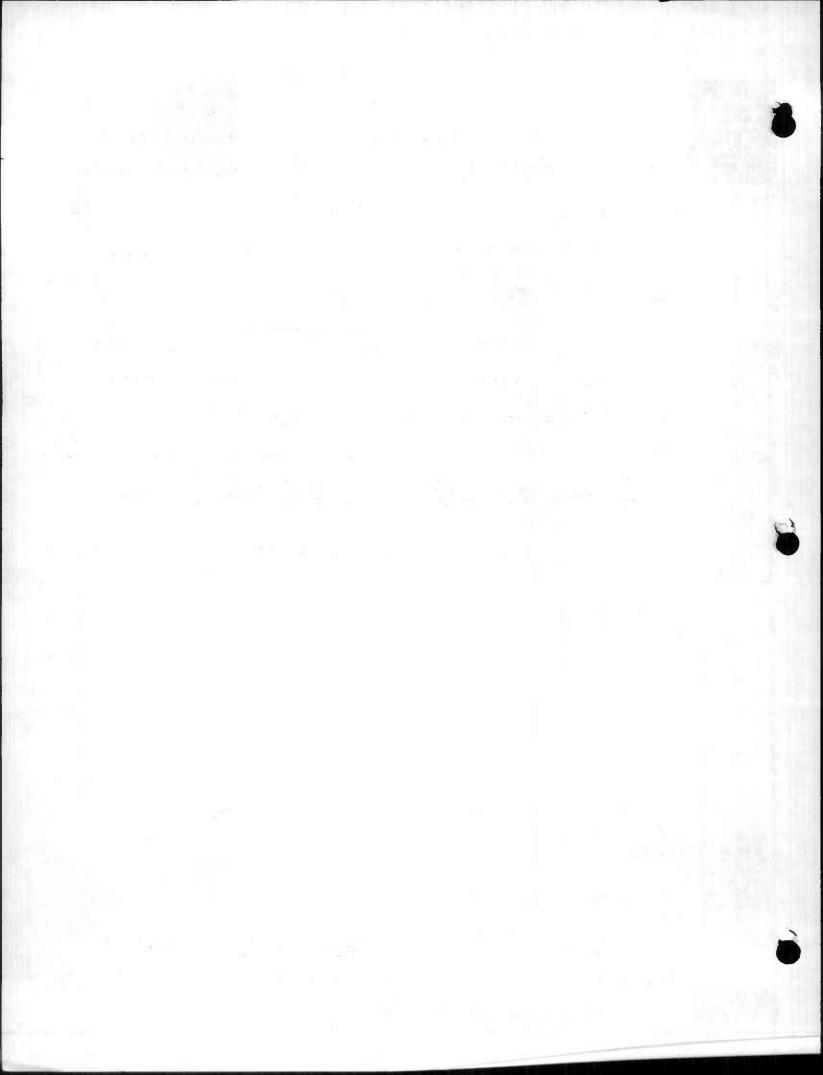
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105

(Type, Print) America Street Cambridge mo 21613

State Registrar

32. Registrar's Signature
2 3 1998 Jahin Marchall 31. Date filed (Month, Day, Year)



Baltimore, Maryland 21215-0020

Physician /Medical

Examiner

sician end burlei-trensit

physician s the buriel

ettending for use as

been signed to should be det

page 2

certificate

Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certificatiely filled in by the funeral director;

To the Hospital
within 24 hours a
To the Funerel C

The law requires that the death certificete be executed

P.O. Box 68760.

Records,

Division of Vital

Examiner

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Completed

Be

edicai Certification: To

4 Homicide

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Dec Ma

						C	ertifica	te oi	f Death		,	Reg. No.	10
Physic /Medi		1. Decedent's Neme LAWRENC			BRIGH	TFUL				- 8	2. Date of De Month MARCH	Dey 14	9 ^{Yeer}
Exami		4e. Fecility Neme (If	not institution,	give street end n	um <i>ber)</i>			1	4b. City, To	wn, or L	ocation of Deeth	4c. Coun	ty of Deeth
		525 CAF	RROLLT	ON DR	IVE				FRED	ERI	CK	FREI	DERICK
Funeral Director		5. Sociel Security Nu 219-07-		5. Sex 17∑ M 2□ F		yrs. lest birthda Yrs.	Months			Main	8. Dete of Bir (Month, De SEPT.	29, 22	9. Birthpled Country MD •
ъ		Usual Residence of	Decedent										
the Merylan 28a-f show	Director	MD •	10b. County FREDE	RICK	100	c. City, Town or FREDE							10d
r 28a-f	Je l	10e. Street and Num	ber				10f. Zij	p Code				10g. Citizen of	Whet Country
th with		525 CA	ARROLL	TON DR	IVE		213	701				U.S	5.A.
within 72 hours after deeth with the Menyland within 72 hours after deeth with the Menyland and "he "sea" stage or 28a-f show than "heturel", or items 23a or 28a-f show as Medical Enaminer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Wes Da Armed F 1 X Yes If Yes, G Yeer or	Forces? 2 No Rive	In U,S. 13	3. Was Dace If Yes, spe 1 \(\superscript{\text{Yas}}\)				pecify Yas or No Rican, atc.)	-	ace - Amarican eck, Whita, at ify: BLAC
72 h	et e	(Special	15. Decedent's	Education grade completed	0	16e. Dec	edent's Usu	el Occi	upation e duning mos red)	t of word	kina	16b. Kind of	Business/Indu
TITLE	Completed	Elemantary/Secon	dary (0-12)	-	(1-4or 5+)		SMAN	ise retir	ed)	COLWON	Virig	FURNI	CURE I
d 2 should be filed to and Mental Hygin 7 is marked other traumatic event,	o Be	17. Fether's Neme (F	irst, Middle, La						18. Mothe MAZ		e (First, Middle, THOMA		eme)
Tand 2 should be file the little and 2 should be file the little and Mental Hy em 27 is marked oth wher traumatic event	F	19e. Informent's Nar SHIRLEY			DAUGH		-				ral Route Number		
Pages nat: If it		20e. Method of Disposition 1 Special 2 C 4 Donetion 5	Cremetion 3	3 □Removel from	n Stete	Ob. Plece of Dis	position (Ne rematory or o VEN	me of other pl MEM	• GAR	. M	Deta AR. 18		RED. M
DOILLING permit. Pe Departmen important: any injury		21. Signature of Fun	erel Service Li	gensee P	20.				ress of Fecili	,	FUNER	AL HO	4E

19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY FOSSETT (DAUGHTER) 519 N. BENTZ ST. FREDERICK MD. 21701

GARY L. ROLLINS FUNERAL HOME

Enter the dimase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line.

FURNITURE IND.

4:15 AM

9. Birthpleca (Stete or Foreign Country)
MD •

10d. Inside City Limits 1 Yas 2 No

Immediate Cause (Final disaase or condition resulting in death)

ADENOCARCINOMA OF THE LUNG Due to (or es e consequence of):

2 MONTHS

Due to (or as a consequence of)

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate causa. Enter Undarlying Couse (Diseese or injury that initiated events resulting in deeth) Last Physician/Medical

Pert II. Other algorificant conditions	contributing to death	but not resulting in	the underlying cau	se given in Pert I.

23b. Did tobacco use contribute to the cause of death?

Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were eutopsy findings available prior to completion of causa of death? 1□ Yes X No

1 ☐ Yes 2 No 25. Was case referred to medical examiner? 28. Place of Death (Check only one)

Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

1 Yes 2 No 2□ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the ceuse(s) egd manner stated.

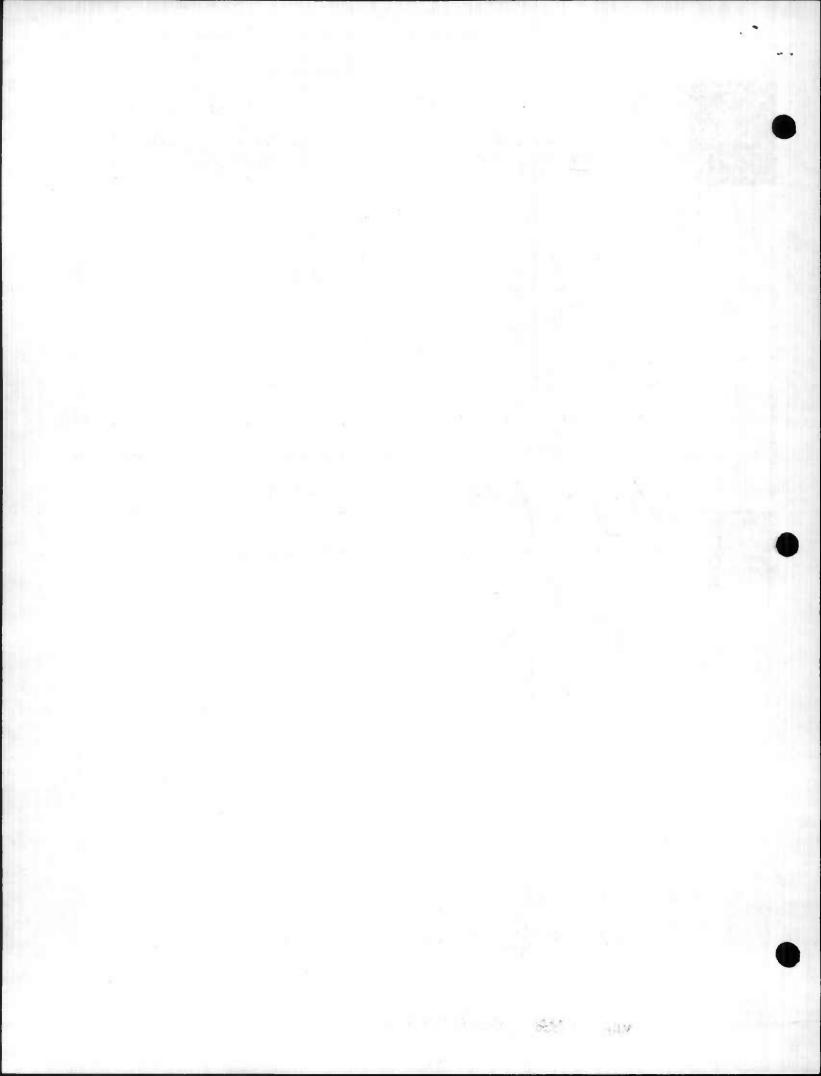
29b. Signature and tile of certifier 29c. License number 29d. Deta signed (Month, Dey, Year) MD D31761

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BRIAN M. O CONNON : UP 50 W. SEL 701 21 50/ W. SEVENTH STO 31. Dete filed (Month, Day, Year)

State Registrar

32. Registrer's Signeture

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene o

Physician /Medical Examiner Funeral Director	4a. Fecility Neme (If not institution 3834 Jeffer 5. Social Security Number 219–88–9514 Usual Residence of Decedent	son Pike		C	RAMPTON		March	12, 199	98°	8:15 pm
Examiner Funeral Director	4a. Fecility Neme (If not institution 3834 Jeffer 5. Social Security Number 219–88–9514 Usual Residence of Decedent	son Pike								Pun
Director	219-88-9514 Usual Residence of Decedent	6. Sex 7. Age			4	b. City, Town, or Jeffers	Location of Deet	4c. County		lerick
r 28a-f show notified at		1□ M 200F	92 (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	v. Year)	9. Birthp Coun	lace (State or Foreign try) aryland
1.28e	Manual Des	derick	10c. City, Tow		erson				1	0d. Inside City Limits 1 X Yes 2 □ No
300	10e. Street and Number 3834 Jeffer	son Pike			10f. Zip Code	2	21755	10g. Citizen of V	What Coun	try?
*natural', or flame 23e or 28a-f show added Examiner must be notified at letted by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates:			as Decedent of Hi res, specify Cuba	spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)	14. Rac Blac Specify	e - Americok, White, o	
	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5	16a.	Deceder (Give kir life. DC	nt's Usual Occupa nd of work done of NOT use retired	ation furing most of wo	orking	16b. Kind of Bu	usiness/inc	lustry
d out	17. Father's Name (First, Middle,	ast)		Home	maker		me (First, Middle			
15.5	Jacob Hanso 19a. Informant's Name/Relations Joseph E. Cramp	Ilp (Type, Print)		-		and Number or F	lae Kefau _{lural Route Numb} Jefferso	er, City or Town,		Code)
Department of Heat Important: If Item 2 any Injury or other once.	20a. Method of Disposition 1 Surlel 2 Cremation 4 Donation 5 Other (S)	3 □Removel from Stete	20b. Place of Disposition (Name of competery, crematory of other plane) Jefferson Reformer		ion /Name of		Date	20c Location -	City or To	wn, State
	21. Statuture of Funeral Service 23e. Part 1. Enter the disease, or shock, or heart failure. List	- Dasfor	MOOO21	Ke	6 East	Basfor Church	d Funera Street,	Frederi	ck, M	ID 21701 Approximate Interval Between Onset and Death
hysiclan /Medical ixaminer	Immediate Ceuse (Finat disease or condition resulting in death)	a	MAN Due to (or as a							3 YEARS
g physician end es the bunel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): C. Due to (or as a consequence of):									
0 6	resulting in death) Last	d	Due to (or as a c	conseque	nce of):					
ed by the deteched		na contributing to death bu	it not resulting in	n the unde	erlying ceuse give	en In Part t.	23b. Did tobacco usa contrit			the cause of death?
ate hes been signe page 2 should be o							24a. Wes	an eutopsy ormed?	COL	era autopsy findings allable prior to mpletion of cause death?
certificate hes be rector, page 2 s						26 Place of De	ath (Check only		10	Yes No
	1 Yes 2 No	Hospital:	nt 2□ER/Ou	tpatient	3□ DOA Othe	26.	Home 5 Resi	III.	er (Specifi	v)
or death. ector: After this by the funeral d		28c. Injun Work		1	how injury occur		,			
250 1	3 ☐ Sulcide 6 ☐ Could r 4 ☐ Homicide determi	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
n 24 hou ne Funer pletely fill edical								cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
To t com	29b. Signature and title of certifier 29c. License number D31761 29d. Date signed (Month, March 13,									
	30. Name and address of person of Brian M. O Cor					reet, F	rederick	, Maryla	and 2	1701

DHMH 16 Rev 6/95

					State of N	laryland		artment of I rtificate of			giene g	3	0318
		7)	1. Decedent's Neme	(First, Middle, Las	st)	.				2. Dete of De	ath		3. Time of Death
	Physici		Emory J	osenh	Cain, I					Month	Dey 10/	Year	12:05 pm
	/Medio Examir		4a. Facility Neme (If I	-)			4b. City, Town, o	March r Location of Deetl	12, 190		12.05 pm
	LAUITIII		805 North	h Warfie	ld Dr				Mt. Air	217	Enod	ani als	
1	Funeral		5. Sociel Security Nu		-	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Dete of Bir		9. Birthpl	leca (Stete or Foreign try)
	Director		210 01 16	64	M 2□ F	83	Yrs.	Months Deys	Hours Mir	March 2	y, Year) A 191A	Mary	Pand
Ь			219-01-161 Usuel Residence of D	Decedent		0.5			1	Incorcit Z	4,1714	Muly	Lunu
	ylan		10e. Stete	10b. County		10c. City,	Town or Lo	ocation				10	Od. Inside City Limits
	Ma T	Ş	Maryland	Freder	ick	Mt.	Airy						1 Yes 2 No
	r 28	Directo	10e. Street end Numi					10f. Zip Code			10g. Citizen of V	Vhet Coun	try?
	s 1 end 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	alD	805 North	h Warfie	ld Drive			21771			u.s.	۹.	
	ep L	Funeral	11. Meritel Stetus		12. Wes Decedent Armed Forces	t Ever in U,S.	13.	Wes Decedent of I	Hispenic Origin? (Specify Yes or No		e - America	
20	or it	by Fu	1 Never Marrie		1 ☐Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 2 ☑ No		ito i ilouii, oto.,	Specify		white
21215-0020	hour tural	d b	3 Widowed 4	15. Decedent's Ed	Yeer or Detes:			~			16h Kind of D	ralmana Ameri	
15	in 72	Completed	(Specify	y only highest gree	de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Bu	ISINGSS/ING	lustry
12	with ene.	E	Elementery/Second	dery (0-12)	College (1-4or	5+)		kman	/		BEO Ra	PHOA	d
	Hyginther ther		17. Fether's Neme (F	First, Middle, Last)			1.000	. Kanoca t	18. Mother's Na	ame (First, Middle,			u
an	d be	Be	Joseph Eld		in					Mary Sk		-,	
7	d Me	ဥ	19e. Informent's Nan				10b Mailie	ng Address (Street			00	Ctata Tin	O. de l
Maryland	d2 s th an 7 is r		Larry Ca		ype, rimij			Linganor					
	Heall Heall Her ther		20e. Method of Dispo					sition (Neme of	e ku., 1	Dete	20c. Location -		21701
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagnose.		1 Burial 2		Removel from Stete	Mary	etery, crer	netory or other pla	ted	3-11-08			aryland
alt	Departr Departr Imports any Inju		21. Signeture of Fund	erel Service Lican	see	Mecro	22	Church . Name end Addre	ess of Fecility	Stauffer	Funeral	P. Hom	0
m	SSEES		130	/	1/9/		8	E. Rida		slud., Mt			
			23a. Pert1. Enter the	e disease, or comp	olications thet cause	d the death.	Do not ent					Trice Lig.	Approximete
	Physician		shock of heert	feilure. List only o	one cause on eech i	line.		,		,			Interval Between Onset end Deeth
	/Medical		Immediete Cause (F	inel	M /	^ . I.	1	1,	5 Co 14				1 -
1	Examiner		disease or condition resulting in deeth)		· Myol	-aron	al	March				h	ninutes
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	icate be executed physician end s the burial-transit	Examiner	0		b. ———	Due to (or e		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Ć,	ficate be executed physician end as the burial-transi	Exa	Sequentielly list condifient, leeding to lmm cause. Enter Underly Ceuse (Disease or International Course)	nediete		Due to (or e	3 6 0011360	prenica or).				1	
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89	ficat phy as th		resulting In deeth) Le	est		Due to (or es	s e conseq	uence or):					
Box		M			d								
ğ	deeth certifi e attending ed for use as	Physician/M	5										
P.O.	y the	ys	Pert II. Other significa	ant conditions co	entributing to death t	out not resultii	ng in the ui	nderlying cause gi	ven in Pert I.				the cause of death?
	law requires that the de as been signed by the a o 2 should be deteched to		Hyper	tensiov	1					1 🗆	Yes 22 No	3 Prob	ably 4 Unknown
Records,	sign d be	d by					_			240 1400	an eutopsy	24h We	ere eutopsy findings
Ö	v raquire been si should I	Completed									rmed?	eve	elleble prior to
Sec.	has t	dr.											leeth?
	The la	3								1 🗆 '	res 2 No	1 🗆	Yes 2□ No
of Vital	Physician: The this certificate ral director, pag	Be	25. Wes case referred examiner?	-						eth (Check only o	ле)		
5	his ldi	2	1 ☐ Yes 2 Ø N	0	Hospitel: 1 Inpati		VOutpetlen	I SEL DON	-	Home 5 Resk	denca 6 □Oth	er (Specify)
	D 0 0	ertification:	27. Manner of Deeth	5 Pending	28e. Dete of Inju	ury By Year)	3b. Time of Injury	28c. Inju Wo	ry et rk?	28d. Describe	now Injury occurr	ed	
Sio	Attending or death. ector: After by the fune	cati	2 Accident	Investigation				M 1	Yes 2 No				
Division	al or Attendir s after death. Il Director: Af ed in by the fu	ŧ.	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pieca of in	jury - At home	e, farm, str	eet, fectory, offica		28f. Location (: City or Tox	Street end Numb vn, State)	er or Rura	Route Number,
	rs after al Dir	O											
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier (Check only	Certifying Phy	rsician: To the best Iner: On the basis of	of my knowle	dge, death	occurred et the ti	me, dete end pled	e, end due to the	ceuse(s) end me	nner as st	eted.
	the H		one)		end menner st	leted.	, one or in	reatigation, in my c	spirion, deen occ	direct of the time,	dete end pieca, t	5110 000 10	(iie cause(s)
	To the within 2 To the comple	Σ	29b. Signeture end tit	tle of certifier	(1	Λ	29c. Licens	se number		29d. Dete signed	d (Month, L	Dey, Year)
			• \\ , \\ .	オルリナ	1	n. V	M)	D'00	51924	4	03-1	2.9	8
			30. Neme end eddres	ss of person who c	ompleted cause of	death (Item 2	3e) (Type,		-1-1			Vinds	
					rson, Jr.				e Rd./P.	O.BOX 19	0/Marv1	and	21776
	Sta	te	31. Dete filed (Month,	Dey, Yeer)		rer (Signatur					, -10-2) 10		
	Registra		ΔМ	R1319	38	a man	or Mark	C.U.					

State of Maryland / Department of Health and Mental Hygiene 98 10319

						Cert	tificate	e of	Death		F	Reg. No.	U	100	19
	DI 1		1. Decedant's Nama (First, Middla, L.	est)							2. Data of Dea Month	ith	Veer	3. Tima	of Deeth
	Physici /Medi		Helen Marie Da	augherty							March	12, 1	1998	6:5	5 AM
1	Examir		4a. Fecility Name (If not Institution, gi								cation of Death		y of Death		
			Frederick Memo							leric			deric	k	
	Funeral Director		125-12-5340	Sax 7. Ag 1 □ M 2/1XF	a (In yrs. last b	Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Data of Birth Month, Day NOV • 24	, 1915	9. Birthr Penn	sylva	a or Foreign ania
	pue M.		Usuel Rasidance of Decedant 10a. Stata 10b. County		10c. City, Tox	wn or Loc	ation							Od. Inside	City Limits
	the Maryl 28a-f aho	Director	Maryland Freder	ick	Frede			Code			1.	10g. Citizen of		1 💢 📉	es 2 No
	s 23e or	eral Dir	100 Burgess H		Apt. 20		21	L 70:				U.S	.A.	•	
21215-0020	s 1 end 2 should be filed within 72 hours after death with the Maryland I Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f ahow other traumatic event, the Medical Exampler must be notified at	by Funeral	11. Meritel Stetus 1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedant Armed Forcas? 1 ☐ Yes XXI If Yas, Giva Yaar or Datas:		lf i	Yes, spec	ify Cub	oen, Maxicar	gin? (Spi n, Puarto	ecify Yes or No- Rican, atc.)		ce - Amaric ack, Whita, fy: Wh		
2	72 hc	eted	15. Decedant's E (Specify only highest gr		186	(Giva k	ant's Usua	k dona	during mos	t of work	ina	16b. Kind of E	3usinass/In	dustry	
121	within then then	Completed	Elemantary/Secondery (0-12)	College (1-4or 5	5+)	lifa. De	<i>o not</i> us memak	a retire	ed)			Own 1	Home		
d 2	Hygie ther t	ပိ	12 17. Fethar's Nema (First, Middla, Las	*)					18 Mothe	er's Nema	(First, Middla,				
lan	id be entel ked o	To Be	Joseph	,	K	ING				na	, , , , , , , , , , , , , , , , , , , ,	HENN			
Mar	2 sh and ie m	-	19a. Informant's Name/Ralationship Mr. Thomas C. Dat		usband	b. Malling	Address Burg	(Stree	tand Number	er or Run	al Route Numbe	r, City or Town	, Stata, Zip	ick.	21702 MD
altimore,			20a. Mathod of Disposition 1XX Burial 2 Crametion 3 Department of Company Com	☐Ramoval from Stata	20b. Placa cemati	of Disposi	ition (Nam atory or of	ne of ther pla	ice)	i	Dete 4,1998	20c. Location	- City or To	own, Stata	
Baltii	permit. Pege Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee 1		22. Ke	Nama and eeney	d Addra	ass of Facilit nd Bas	ford	P.A. F	uneral	Home		
	_		23a, Part1, Enter the disease, or con	2- 04	00255						, Frede		1D 21	701 Approxim	
	Physician /Medical Examiner	ner	shock, or heart failure. List only Immedieta Cause (Finel disease or condition resulting in daath)			consequ	asc ence of):	ial Ho	lar l	Ace	ciden	+ /w	and	3do	
	ecuted and transi	Examiner	Sequentially list conditions,	b	Due to (or es e			100	7	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				5/6	00)
x 68760,	eath certificate be executed attending physician end for use es the buriel-transit	Medical	if any, leading to immadiate cause. Enter Underfugge Ceuse (Disaesa or injury that initiated evants resulting in death) Last	c	Dua to (or as e	consequ	anca of):								
BO	es thet the death cer igned by the attendin be detached for use	Physician.		u											
P.O.	0 0 0	nysid	Part II. Other significant conditions	ontributing to death b	ut not rasulting	in tha und	darlying ca	ause gi	iven in Part I	•		obacco uae co			
J.	thet bed by deta	by Pt									124	es 2 No	3 ∐ Pro	bably 4	Unknown
Records,	requir been s should	Completed b									24e. Was a perfor	an autopsy med?	av	ara autops ailabla prio empletion o death?	or to
	The law ste hes page 2	E									1 🗆 Y	as 2010	1[□Yas 2	□ No
Vital		Be	25. Was case refarred to medical axaminar?						26. Placa	of Deeth	(Check only or	ne)			
oto		2	1 Yas 2 Ho	Hospital:	ent 2 ER/O	utpatient	3□ DO	A Ot	har: 4□ Nu	rsing Ho	me 5 Rasid	ance 6 □Ot	her (Specil	<i>(y)</i>	
onoi	ath. arh. r: After thi		27. Mannar of Deeth 1 Naturel 5 Panding 2 Accident invastigation		ry Year) 28b.	Time of Injury	M 28	Bc. Inju Wo	iryat ork?]Yas 2 ☐		28d. Dascribe h	ow injury occu	rred		
Division	s efter de la Directo ed in by t	Certification:	3 Suicida 6 Could not be datarminad		ury - At homa, f c. <i>(Spacify)</i>	arm, stree	et, factory,	, office			28f. Location (S City or Tow	treet and Num n, Stata)	ber or Rura	il Routa Nu	ımber,
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of miner: On the basis of	of my knowledg f axamination a	a, daath o	occurred a estigation,	in my	ime, date en opinion, dea	d plece, th occurr	end due to the d ed at tha tima, d	eusa(s) and m lata and plece	annar as s	tated. tha cause	a(s)
	To the To the Complex	W	29b. Signatura and title of certifler	010			29c.	-	sa number		2	29d. Dete sign	ed (Month,	Dey, Year,)
			Shul	FK	al			D	366	49		3	/12	197	
			30. Nama and addrass of person who											- -	
	-0.	4	Edward P. Riuli 31. Data filed (Month, Day, Yaar)		West No ar's Signetura	inth	Stre	et,	Fred	eric	k, Mary	land 21	.701		-
	Sta Registr	_	MAR 1 3 19	38	ars signatura Davidson	Rendal	61								

State of Maryland / Department of Health and Mental Hygiene

10320

							Ce	rtificat	e of	Death			Reg. No.		10020
			1. Decedant's Nam	na (First, Middle,	Last)						2	. Data of De			3. Tima of Death
	Physic]	FRANCIS		Houst	on	FOR	REMAI	N Sr	N	Month 1arch	Day 15, 1	998	12:15 a.
	/Medi Exami		4a. Facility Nama (giva straat and n					4b. City, Tow				nty of Death	
1	LAUIII		8113	Broadvi	ew Driv	ze.				Fred	erick	C	Fre	derick	ζ
Н	Funeral		5. Social Sacurity N		6. Sex		s. last birthday)	If Under		If Under 2		. Data of Bir (Month, De			
	Director		220-05-6	264	MM 2□F	77	Yrs.	Months	Days	Hours	Min.	(Month, De ine 2,	y, Year) 1920	Mary]	placa (Stata or Foreign intry) Land
	D.		Usuel Rasidance o	f Decedant											
	how		10a. Stata	10b. County		10c. C	City, Town or Lo	cation							10d. Insida City Limits
	Mo Me	cto	Maryland	Frede	erick		Frederi	ck							1 ☐ Yes 2 ☑ No
	ath with the Merylan 23a or 28a-f ehow	Director	10e. Street and Nu	mber				10f. Zip	Coda	0170	1		10g. Citizen o	of What Cou	ntry?
	15 w		8113	Broadvie	ew Dr.					2170	1		U.	S.A.	
	dea ma	Funerai	11. Maritel Stetus		12. Was De	cedent Ever in	U,S. 13.	Was Dece	dent of H	lispanic Orig an, Mexican,	in? (Specif	fy Yas or No		ace - Amari	
0	72 hours after death with the Meryland "natural", or items 23a or 28a-f show indical Examiner must be notified at			riad Marrie	d TYas, G	2 No		1□ Yas		Specify:		.,,	Spec		lack
200	ours	d by	3 Widowed	4 Divorcad	Yaar or	Datas:							Spec	ony. Di	.ack
5	hin 72 ho	Completed	(Spec	15. Decedant's cify only highast	Education grada complated	()	18a. Deced	dant's Usua kind of wo	al Occup rk dona	ation during most d)	of working		16b. Kind of	Businass/Ir	ndustry
121	2 . 5	Jq II	Elementery/Seco	ondary (0-12)		(1-4or 5+)									
7	TIC		12 17. Fathar's Nama	/P** A A A A A A A	4		Labor	atory	Tec	hnici					rnment
anc	0 E 7 A	Be	John Alb										Maiden Sum	ame)	
3	should be and Mental marked o	2										derso			
Baltimore, Maryland 21215-0020	C1 W		19a. Informent's N Janet For										er, City or Tov		
e,	C = 0 F				wile	1006				Drive			ck, Man	·	
0	8 5 2		20a. Mathod of Dis 1₩ Burial 2	,	3 □Removel from	Stata	Placa of Dispo cemetery, crar	natory or o	thar plac	ce)	1	Dete	20c. Locatio	n - City or T	own, State
Ħ	men men men men men men men men men men	.41		5 □ Othar (Spe		Fa	irview	Cemet	ery		3-1	9-98	Freder	cick,	Maryland
Sall	permit. Pege Department of Important: If any injury or once.		21. Signatura of Fu	unarai Sarvica Li	cansaa	/	22	2. Name en	d Addra	ss of Facility	Stau	ffer	Funeral	L Home	
ш	205 2 3		The	marie	New York	terze	$y \rightarrow 1$	621 0	poss	umtow	n Pik	e, Fre	ederick		
	_		23a. Part1. Frier t shock, ir has	tha disaase, or or	omplications that	caused the dec	eth. Do not ant	ar tha mod	a of dyln	ng, such es c	cardlec or r	espiratory a	rrest,		Approximete Intarval Between
	Physician		0		y ona oasoa on	arabi iii iga								1	Onsat and Death
	/Medical	П	Immedieta Causa disaasa or conditio		Co	RONAL	2V A	RTEI	24	DIST	TACI				FRW MONTH
	Examiner		rasulting in death)		a	RONAL.	(or as a consec	uence of):		90,0	7/1/6				FEW YEARS
-	D .=	ner			A	THERO	SCIERI	2015							FEW YEARS
	nd frans	Examiner	Sequantially list co	anditions,	D		(or as a consec							1	
ó,	icete be executed physician end s the buriel-transit	ũ	Sequantially list co if any, laading to in cause. Enter Unde Cause (Disaasa or	nmadiata artying										i	
68760,	hysic the b	edical	thet initiated evants rasulting in death)	S	C	Dua to (or as a consaq	uanca of):							
9 x	certificete be executed vding physician end use es the buriel-transit	ЛМес			ل ا									ļ	
Bo	- 23	lan/			G										
	0 0 8	Physician	Pert II. Other signif	ficant condition	s contributing to	death but not re	sulting in the u	ndarlying c	ausa giv	en in Part I.	7	23b. Did	tobacco use	contributa i	to the cause of death?
P.0	thet the led by th detach		DIABATE	5 ME	TUITUS	4	YPERTE	NRIN	V			10	Yes 2)X No	3 □ Pro	bably 4 Unknown
	igne bed	by	D.117010	7 1110	wijos		1101010	7 4 37 07	•						
Division of Vital Records,	w requires that been signed to should be det	Completed	CARDINE	ARRH	YTHMIA	CI	RIMA	na (nec.	N		24a. Was perfo	an autopsy med?	an	/ara autopsy findings vellebla prior to
ec	@ S CV	ηple	0						UVI	,					ompletion of causa f daath?
E .	The page	50	VERIFHE	RAL	VASCUC	AR DI	SEASE.		VA			10	Yes 20 No	1	☐ Yas 2☐ No
ita	Physician: The ratio of the contificate and director, pages	Be (25. Was casa rafar axaminer?				- 0/1/0		V . /	26. Piaca	of Daath (6	Check only o	na)		
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D L	ding Ph h. After th funeral		27. Mannar of Deet		28a. Data (Moi	of Injury oth, Dey Year)	28b. Tima of	2	8c. Injur Wor	y at k?	286	d. Dascribe I	now injury occ	curred	
000	Attending or deeth. actor: After by the fune	atic	27. Mannar of Deeth 1 Naturel 5 Panding invastigation 3 Sulcida 4 Homicida Homicida 28a. Data of Injury (Month, Dey Year) 28b. Tima of Injury M 28c. Injury at Work? 1 Yas 2 No 28d. Dascribe how injury occurred 28d. Dascribe												
<u>X</u>	i or Attend efter deeth Director: / d in by the i	t t	3 ☐ Suicida 4 ☐ Homicida	6 Could no determin	ed 28a. Plac	a of Injury - At I	home, farm, str	aat, factory	, office		281	f. Location (S City or Tox		mber or Rur	ral Routa Number,
	rs ef	Cer													
	lospi I hou uner uner	edicai	29a. Certifier (Check only	1 Certifying	Physician: To the kaminer: On the l	a bast of my kn	owledga, death	occurrad	at tha tin	na, deta and	placa, and	d dua to tha	causa(s) and	mannar as	stated.
	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: Affer thi completely filled in by the funeral		one)		and mei	nnar stated.					. 00001100	at tree titted,			
	or with the second sec	Σ	29b. Signatura end	titla of cartifiar	Dans	m	m	290		e number			29d. Data sig		Day, Year)
				4	1000	/	110		D	1806	15		3/16	198	
			30. Nama and addr		ho complated cau	ise of deeth (Ite	m 23e) (Type,	Print)		Fn		4	100	701	
			ABOUL	MAJO	EED	801 To	LL House	E AVE	5. 1	KEDE	RICK	= m	10 217	101	
	St		31. Data filed (Mon	ith, Day, Year)	32.	Registrar's Sign	natura								
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DH	MH 16 Rav 6/9	5	. 171	UII 7 .	0			-1							

MAR 1 = 1550

				Certificate of		F	leg. No.	3 1	0321
Physici /Medic		1. Decedent's Name (First, Middle, Last) Willis Raymond	GOUGE			2. Dete of Dea Month March 1!	5, ^D 1998	Year	3. Time of Death
Examir	ner	4e. Fecility Name (If not institution, give street and numb Frederick Memorial Hos		4	lb. City, Town, or L Frederi		111111111111111111111111111111111111111	of Death erick	
Funeral Director		239-72-0056 X [™] 2□ F	Age (In yrs. last bir 52	thday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug • 10	3, 1945	9. Birthole Country North	ace (State or Foreig
Maryland a-f show	tor	Usual Residence of Decedent 10e. State 10b. County Maryland Frederick	10c. City, Tow Walk	n or Location ersville				10	d. Inside City Limits
th with the 23a or 28	al Director	10e. Street end Number 37 Maple Avenue	'	10f. Zip Code 21793			U.S.		y?
permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23a or 28e-f show eny injury or other traumatic event, the Medical Experient main be notified at once.	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Deced Armed Force 1 Yes 2 If Yes, Give' Yeer or Date	es? XNo	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes X2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, et Whit	tc.
d within 72 ho piena. r than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4)	or 5+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired ashier/Clerk	duning most of work f)	king	16b. Kind of Bu		stry Station
2 should be filed with and Mental Hygiena. • marked other than sumatic event, the M	Be	17. Father's Name (First, Middle, Last) Luman Benson GOI	JGE		18. Mother's Nam			(e)	
2 should be and Mental is marked or sumatic eve	To	19a. Informant's Name/Relationship (Type, Print)		. Mailing Address (Street	Ella and Number or Rui	Mae ra <i>l Rou</i> te Numbe	COLE r, City or Town,	State, Zip (Code)
1 end 2 Health am 27 i		Mrs. Marjorie L. Gouge, w. 20a. Method of Disposition		7 Maple Ave. Disposition (Name of	, P.O. B				
Peges ent of int: If its ry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	cemeter	ry, crematory or other place an Cemetery, Ma		Date	20c. Location - Bakersvil		rth Carolin
permit. Peges 1 Department of Inportant: If its eny injury or ot		21. Signature of Funeral Servica Lidensee	MO0255	Reeney and 106 East C	s of Facility Basford	P.A. Ft	neral F	Tome	
Physician /Medical Examiner buthe private pri	cal Examiner	Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	Due to (or as e	aden o Consequence of):	acinm	nuif	lung		Onset and Death Mornil
deeth certiff e ettending od for use er	Physician/Medical	dPart II. Other afgnificant conditions contributing to deat	Due to (or as a o		en in Part I.	23b. Did to	/		the cause of death
aw requi	Completed by F					24a. Was a	in autopsy	24b. Wen	e autopsy findings lable prior to pletion of cause eath?
The age	0	25. Was case referred to medical			26. Place of Deet	1 🗆 Y		10	Yes 2□ No
0 0	To B	exeminer? 1 Yes 2 No Hospitai: 1 Inp			er: 4 🗆 Nursing Ho			er (Specify)	
ing Afte	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be	28c. tnjury at Work? 1 Yes 2 No			S. A. W			
े ई हैं ⊆		determined 200. Flace of	njury - At nome, ta , etc. (Specify)	rm, street, factory, offica		28f. Location (S City or Tow		er or Hurar	Houte Number,
Hospital 24 hours Funeral Hotaly filled	edical	29a. Certifier (Check only one) Certifying Phyalcian: To the besiend manner on the basiend manner	s of examinetion en	, death occurred at the tim d/or investigation, in my op	ne, date end place, pinion, deeth occur	and due to the c red at the time, d	ause(s) and ma late and place,	nner as sta and due to t	ted. he cause(s)
To the within 2 To the comple	M	29b. Signeture end title of certifier	IM N	29c. License			9d. Date signed		
		1 Wollah	_ "W	D	48186	M	larch 16	, 199	18
		30. Name and eddress of person who completed cause of Elhamy Eskander, MD, 503			Freder	ick Mar	wland (21.701	
				ACTION DETCE	. TICUCI.	TCK, Hai	y Lanu 2	TIOI	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 12 1998 1998 Helen Roberta GROSSNICKLE 10:05 am /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Homewood Retirement Center Frederick Frederick 5. Social Sacurity Number If Under 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 20, 1905 Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funerai** 10 M 24 F Days 214-10-2947 93 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location show 10d. inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla popertment of health and Mental Hygiene. Important: It fam 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, its Meaner Examine maint or notived in Maryland Frederick Frederick Director 1X Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 31 West Patrick Street 21701 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American indian, Black, White, etc. I ☐ Yes 2 🕱 No If Yes, Give 1 Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: by Specify: 3 ₩ Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Clerical Work Factory 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Clinton **ECKARD** Augustua Marcie **GEISELMAN** 2 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Fern Poole Mercer/POA P.O. Box 240, Frederick, Maryland 21705-0240 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Ramovel from State Resthaven Mem Gar Mar 14, 1998 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Lie 22. Name and Address of Facility. Keeney & Basford P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 Entar I/A disea a, or complications that ceusad the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, or he infailure. List only one cause on each line. **Physician** /Medicai immediate Cause (Final UTERINE CANCER diseasa or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Couse (Disease or injury that initiated events rasulting in death) Last for usa es the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 25 No 3 Probably 4 Unknown ZHEIMER'S DEMENTIA þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy 1 Yes 2 No this cartificate 1 ☐ Yes 2 No Attending Physicien: Be 25. Was cese referred to medicei 26. Piaca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral i 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Naturai 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicida 28e. Place of injury - At home, farm, atraat, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicida Medicai 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signeture and titla of certifier 29c. Licensa number 29d. Dete signed (Month, Day, Year) Soulyne D21936 March 13, 1998 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) Andrew O. Donelson, M.D., 915 Tollhouse Avenue, Ste 203, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

John Studen Randell

DHMH 16 Rev 6/95

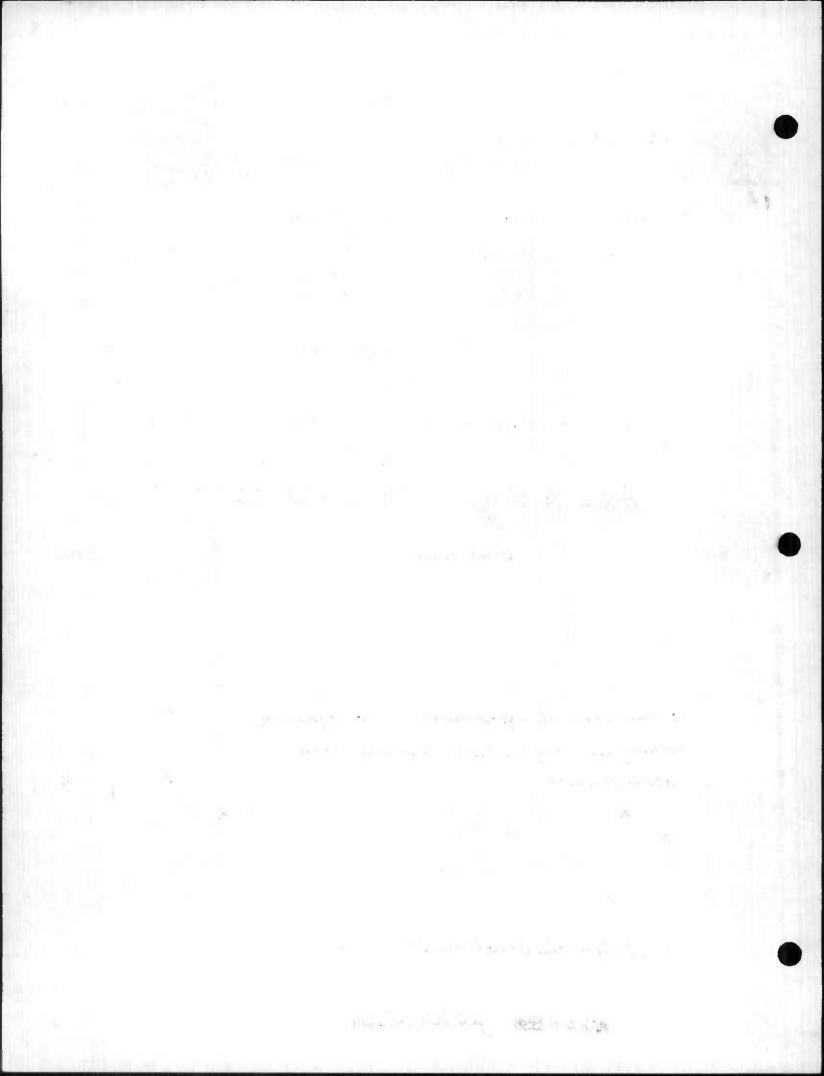
Mary State of the State S AAM

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Lu HOFFMEISTER Month 18^{Pay} Ethel March 7:20 A.M. /Medical 4a. Facility Nema (If not Institution, giva street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner 3771 Point of Rocks Road Point of Rocks Frederick 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Oct. 24, 1910 5. Social Sacurity Number 9. Birthplaca (Stata or Foreign Country) New York **Funeral** 1 M 2 XF 579-50-7146 Director Usual Rasidance of Decadant the Maryland 10a Steta 10b. Count 10c. City, Town or Location 10d. Insida City Limits rei', or items 23s or 28s-f show Exercises roust be notified at 1 ☐ Yes 2X No Maryland Frederick Director Point of Rocks 10f. Zip Coda 10a. Street and Number 10g. Citizan of Whet Country? 3771 Point of Rocks Road 21777 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. filed within 72 hours after 1 ☐ Navar Marriad 2 🕅 Marriad Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yas 2 X No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorcad White h and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 15. Dacadant's Education (Specify only highast grada completed) 16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Agriculture Organic Farmer 17. Falhar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be permit. Peges 1 and 2 should be 1 Depertment of Heelth and Mental I Important: If Item 27 is marked of any injury or other traumatic even **EDELMAN** John Anna SUTTER 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Thomas M. Hoffmeister, Husband P.O. Box 154, Point of Rocks, MD 21777 20b. Place of Disposition (Nama of cametary, crametory or other place) 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Slale 4 ☐ Donation 5 ☐ Othar (Specify) Mount Olivet Cemetery, Mar. 21, 1998 Frederick, Maryland 22. Name end Addrass of Fecility Keeney & Basford P.A. Funeral Home 21. Signetura of Funaral Sarvica Licensas 94 Ruby M00703 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disaasa, or complications that consed the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on high line. Onsat and Death **Physician** /Medicai Immadiata Ceusa (Final DEMENTIA 3 YRS disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner Sequenfielly list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Disaasa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequance of): physician s the buriel Box 68760. Physician/Medical Due to (or es a consequença of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 □ Probably 4 □ Unknown NORMAN PRESSURE HYDROCEPHALUS Z° to CRYPTOCOCCAY þ 24b. Wara autopsy findings availabla prior to complation of causa of daath? Completed 24a. Was an autopsy performed? MENINGITIS, DEGENERATIVE ARTHUTIS, CVA, 1□ Yas 2XNo HYPERTENSION 1 ☐ Yas 2 No Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 K Rasidance 6 Othar (Specify) Certification: To 1 Yas 2XNo this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Panding ne Hospital or Attending n 24 hours after death. ne Funerel Director: Afte 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At homa, ferm, straat, factory, offica building, atc. (Spacify) filled in by 4 Homicida 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Şignature and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Dey, Year) Indrew O. Smelson > March 18, 1998 D21936 30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print) Andrew O. Donelson, M.D., 915 Toll House Avenue, Frederick, MD 21701 32. Registrar's Signatura 31. Dete filad (Month, Day, Year)

Jalin Davidson Rankelle

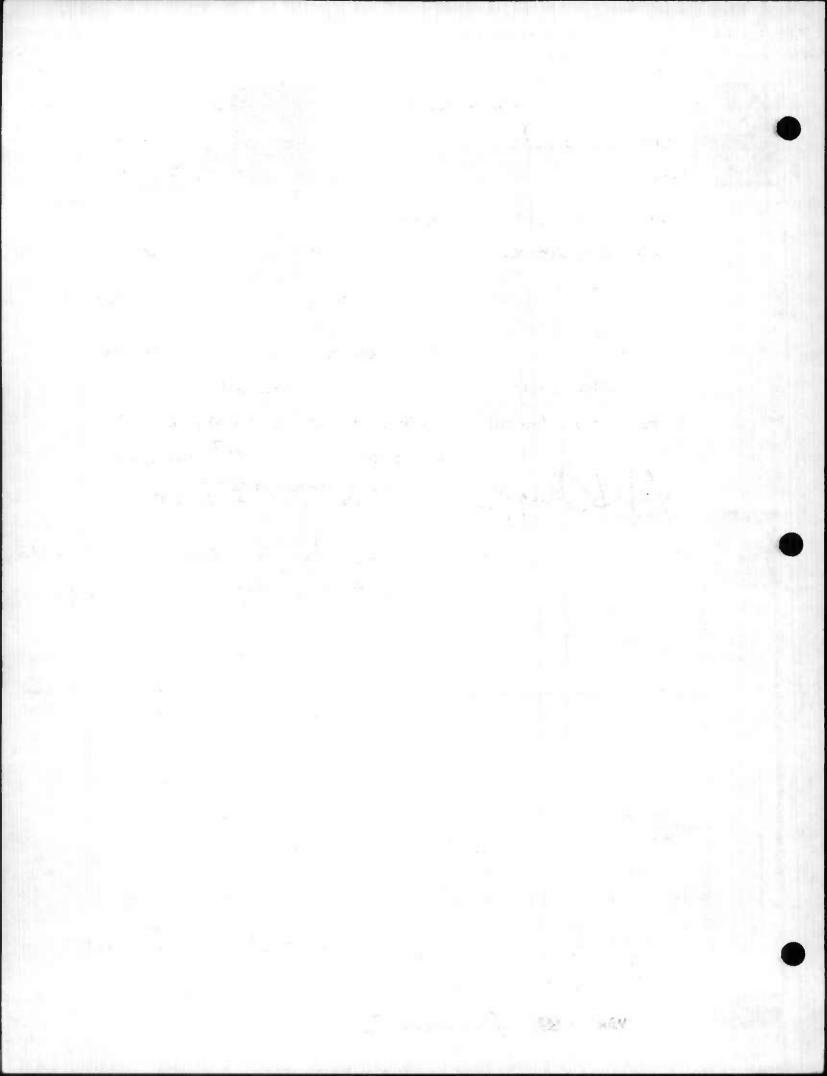
DHMH 16 Rev 6/95

State



State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of i	Death			Reg. No.		10024
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Exami		4a. Facility Name (, giva street and nu hurch Rd.	imber)			4		wn, or Lo	ocation of Daa		unty of Death	1
Funeral Director		5. Social Security N 214-48-432	6	6. Sax 1 ☐ M 2 💢 F	7. Aga (In yrs	. last birthday Yrs.		Year Days	If Undar: Hours		8. Data of Bi	nth Y 1918	9. Birth	nplaca (Stata or Foreig untry)
wor.		Usual Rasidance o	10b. County		10c. C	ity, Town or L	ocation							10d. Insida City Limit
e Mar	ctor	Ml.	Frede	rick		Myersv	ille							1 □ Yas 2 N
with th	Dire	10e. Street and Nu		Church Rd.			10f. Zip (Coda 217	773			10g. Citizan U.S	of What Cou	intry?
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uraf, c	d by	3 Widowed	4 Divorced	If Yas, G Year or I	rva		1□ Yes 2	(X(No	Specify:			Spe	ecity: Whi	te
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d 2 s		19a. Informant's N G. Russell			4)						al Routa Numb Nersvill			ip Coda)
of Heali item 2 other		20a. Method of Dis	position		20b.	Place of Disp	osition (Name	e of		u., r	Data		on - City or T	Town, State
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permit. Page Department of Important: If any injury or once.		21. Signatura of Fo	uneral Sarviced	Maria)	1]	2. Name and Donald I 31 E. M	Addre B. II	ss of Facility Compsor	Fune	eral Home	21769		
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certificate be executed ofing physician and use as the buriel-transit	//Wedical	Causa (Disaase or thet initiated evant rasulting in death)	S	d	Due to (or as a conse	quence of):							
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To the comple	29b. Signature end titla of carity 29d. 29c. License number 29d. 29d. D0 95/8 30. Name and address of parson who completed causa of daath (Itam 23a) (Type, Print) D.R. Poirier, M.D. Kornowus Johnson Dr. Frederick									29d. Data signad (Month, Dey, Year)				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Daeth 3. Time of Death Month **Physician** 15, 1998 4:05 PM OLA ELIZABETH MILLER March /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehabilitation Ctr. Walkersville Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 20 F 1911 Maryland 220-26-0302 Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Frederick Thurmont Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 6831 Red Bird Lane 21788 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ②☐ No if Yas, Giva Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Bieck, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas ¾ ☐ No Spacify: by Specify: 3 √Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Elementary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) William Baker Anders Sarah Isabelle Sweeney 19a. Informant's Name/Raiatlonship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Virginia Dayhoff (Daughter) 6827 Red Bird Lane, Thurmont, Maryland 21788 20e. Method of Disposition 20b. Piaca of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Stete 1 Buriai 2 □ Cramation 3 □ Ramovai from Stata 3/18/98 Lewistown, Maryland Lewistown Cemetery 4 Donation 5 Othar (Specify) 21. Signature of Fig. 22. Nema and Addrass of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediata Causa (Finai disaasa or condition rasulting in daalh) Musli Sequentially list conditions, if eny, leeding to immadiate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medicai Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medical Be 26. Placa of Daath (Check only one) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 20 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of 1 DNatural 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 3 ☐ Suicida 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifian Medical 29b. Signatura end title of cartifian 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic avant

Physician /Medicai

Examiner

burial-transit

signed by t

page 2 should

this certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies

in by

and physician s s the burial

P.O. Box 68760.

Records,

Division of Vital

The law requires that the death certificate be

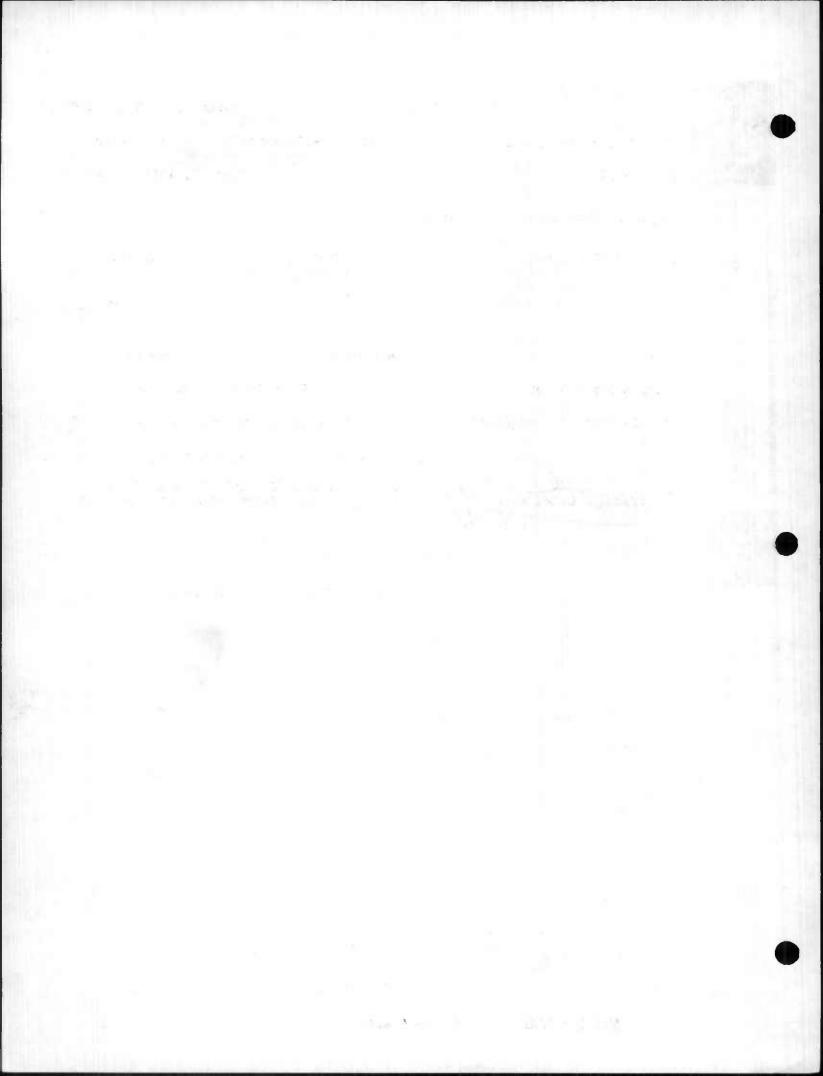
altimore, Maryland 21215-0020

Francis E. Becker, MD

31. Data filad (Month, Day, Year)



300 West 9th Street, Frederick, Maryland 21701



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 13, 1998 Ellen Margaret ROHRER March 6:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Vindobona Nursing Center Braddock Heights Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Deys Hours 117-07-1655 Yrs. 91 Director Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylen Department of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Mudical Examines must be notlined. Maryland Frederick Braddock Heights 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6021 Jefferson Blvd 21714 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 2\sum No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: White b 3℃Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Librarian Public Schools 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be F ROHRER Harry Dessie HARP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) David H. Rohrer 10 S Jefferson Street, Frederick, Maryland 21701 20b. Place of Disposition (Name of cametery, crematory or other place)

Smithsburg Crematory Mar 16,1998

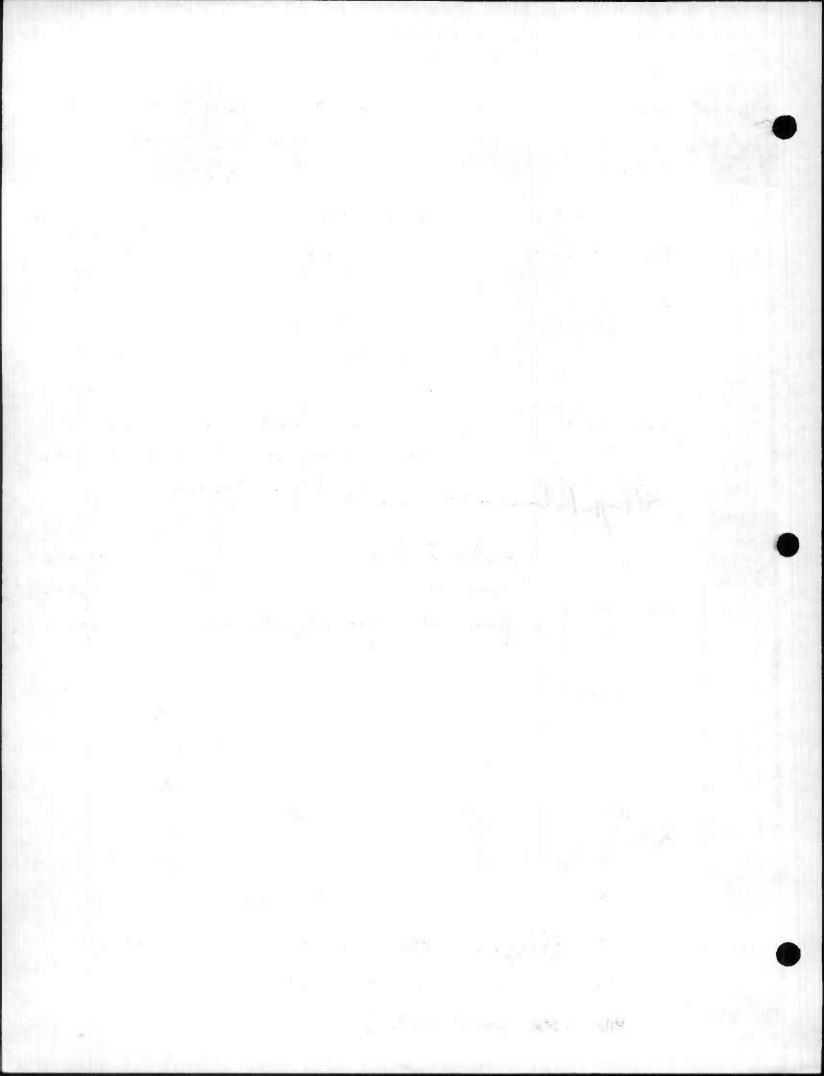
Smithsburg, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home M00706 106 E Church St, Frederick, Maryland 21701 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner physicien end the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or este consequence of) Derionalit Box 68760, Physician/Medical ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by t 1□ Yes 2⊠No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy peed hes certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 12 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete and placa, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D16675 March 13, 1998 30. Name end address of person who completed pause of death (Item 23a) (Type, Print) Wayne Allgaier, M.D. 610 Ninth Avenue, Brunswick, Maryland 21716 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Jalia Devileon Rookal

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Physician Month 1998 March 3:30 AM John Albert Sanders /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e. Facility Nama (If not institution, give street end number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Dafa of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1MM 2□ F 202-10-4728 73 Yrs. Director Pennsylvania Usual Rasidance of Decedent the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ? is marked other than "natural", or items 23s or 28s-f show traumatic event, the Med cal Examinar must be notified at Maryland Frederick 1 XYaa 2 No Frederick Director 10e. Streef end Number 10f. Zip Coda 10g. Citizan of What Country? 2431 Bear Den Road 21701 U.S.A. Funeral 12. Wes Dacedenf Ever In U,S. Armed Forcas? Wes Decedent of Hispenic OrlgIn? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Rece - American Indien, Biack, Whita, etc. permit. Peges 1 and 2 should be filled within 72 hours effer of Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples. 1X Yas 2 No 1943− If Yas, Giva Yaar or Datas: 1946 1 Never Married 20 Married 1 Yas 2 No Specify: White À 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grade complated) 16b. Kind of Businass/Induatry Elamantary/Secondary (0-12) Collega (1-4or 5+) Attorney Private - Law 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) John William SANDERS Anna Marie KRUTHERS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Mildred Sanders/Wife 2431 Bear Den Road, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBurial 2 Cramation 3 Ramoval from Stata Indiantown Gap Cemetery Mar16,1998 Annville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 Cot. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such ea cardiac or raspiratory arrast, shock, or heart for urn. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medicai Immediata Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 48 Unknown 1 | Yes 2 | No þ 24b. Were autopsy findings available prior to 24a. Waa an eutopay performed? Completed peen complation of causa of death? hes 1 Yas 2 No 1 Yas 2 No the Hospital or Attending Physician: thin 24 hours efter death. the Funeral Director: After this certifical mpletely filled in by the funeral director, 25. Waa casa rafarred to madical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Unpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Panding invastigation 1 Tas 2 No 2 ☐ Accidant 6 Could not be 3 ☐ Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, offica building, atc. (Spacify) 4 Homicida 29a. Cartifian 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical 2 Madical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the ceuse(s) and manner stated. To the within 2 29d. Daia signed (Month, Day, Year) 29b. Signeture end title of entitier 29c. License number D21648 30. Nama and addrasa of person who complated causa of death (Itam 23a) (Type, Print) Street Figure MD 21701 KNSA-1 BARAKAT

State Registrar

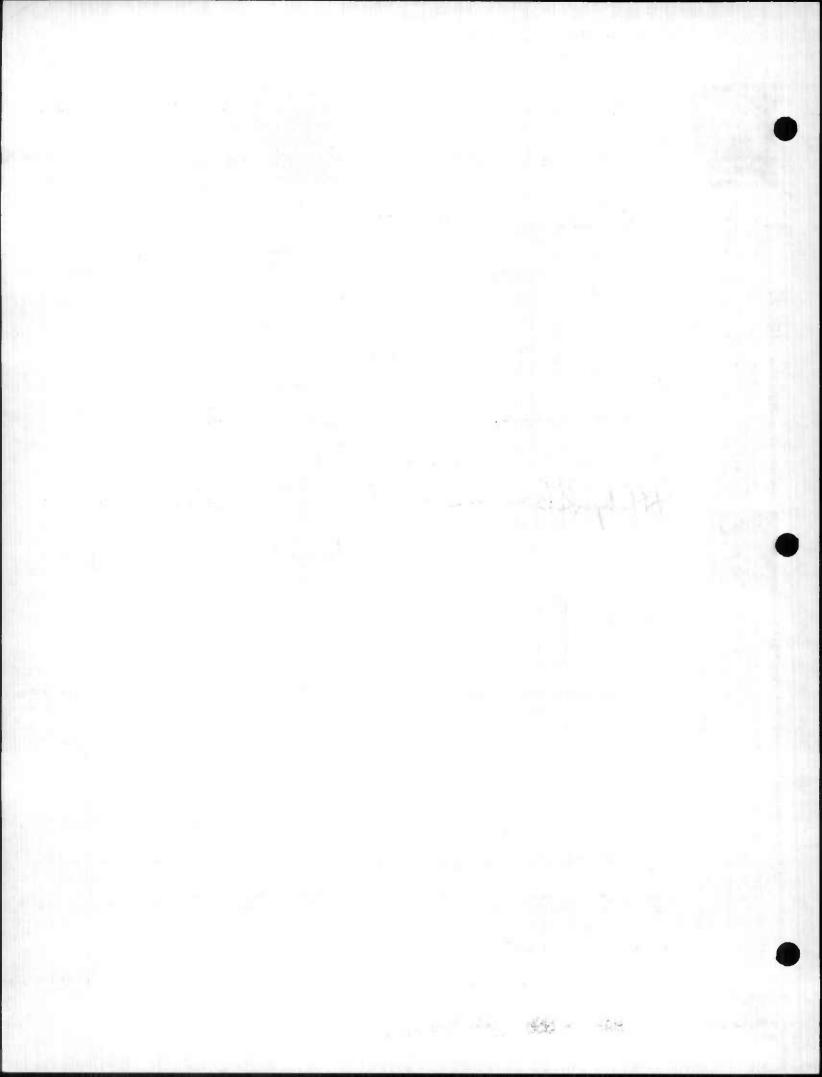
31. Data filed (Month, Day, Year)



Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

	State of Marylan		rtment of		and M	, ,		103	328
Decedent's Name (First, Middle, Last	"					2. Deta of Death	g. No.		3. Time of Death
John Warren	Seniff					March 17	7.1998	Yeer	9:00p.m.
4e. Fecility Neme (If not institution, give				4b. City, To	wn, or Lo	ocation of Deeth	4c. County	of Death	
Frederick Memor	ial Hospital			Frede		K	Free	deric	k
347-24-2337	X		Months De		24 Hrs. Min.	8. Date of Birth (Month, Dey, Jan 19,	1931	9. Birthp	elece (Stete or Foreign http) 1001S
Usuel Residence of Decedent 10a. Stete 10b. County Maryland Frederic		rown or Local					_	1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
10e. Street end Number 10401 Pleasant Vi	sta Drive		10f. Zip Cod	2170)1	10	g. Citizen of \	Whet Cour	etry?
11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 XYas 2 No 1951 If Yes, Give Year or Detes: 1953	L- 1	las Decedent of Yes, specify C		gin? (Sp , Puerto	ecify Yes or No- Ricen, etc.)	14. Rac	e - Americ ck, White,	
15. Decedent'e Edu (Specify only highast grad	icetion	16a, Decede	ent's Usuel Oci	cupation ne during most	t of work	ina 1	6b. Kind of B	usiness/in	dustry
Elementery/Secondery (0-12)	College (1-4or 5+)	Manag	O NOT use ret	ired)			Manufa	actur	ing
17. Fethar's Neme (First, Middla, Last) Russell W	ade SI	ENIFF		Glad		a (First, Middle, M Sara			RYE
19a. Informant's Neme/Reletionship (7) Mrs. Martha A. Sei						el Route Number, Dr, Frede			code) land 21701
20e. Method of Disposition 1 Buriel 2 Coremetion 3 F 4 Donetion 5 Other (Specify)	Removel from State Smi	lece of Disposi emetery, creme thsburg	story or other I	olece)	ar 1	1	oc. Location - Frede		wn, Steta , Maryland
21. Signeture of Funeral Service Licens	D		Keene	drass of Fecility & Bas	for	d P.A. Fo	uneral	Home	701
23a. Fam. Enter the disease, or complete the disease, or heart feilure/ List only or								10 21	Approximate Interval Between Onset and Deeth
Immadiate Cause (Finel diseese or condition resulting in death)	CVA -							1	3 WKS
	b	res a consequ						1	
Sequantielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	es a conseque							
Tooding in death, East	d								
Pert II. Other significant conditions cor	ntributing to death but not resu	ilting in the und	derlying ceuse	given in Pert I	•	23b. Did tob	acco use co	ntribute to	the cause of death?
						1)2/10	8 2□No	3 Pro	bably 4 Unknown
						24e. Wes en		ev	ere autopsy findings ellable prior to mpletion of ceuse deeth?
						1 ☐ Yes	2 No	1[Yes 20 No
25. Wes cese referred to medical examiner?				26. Plece	of Deat	h (Check only one			/ \
1 ☐ Yas 2 No		ER/Outpatient	3LI DOA		rsing Ho	me 5 Residar	nce 6 Oth	ar (Specif	y)
27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury		njuryet Vork? □ Yes 2 □ I	No	28d. Describe how	w injury occur	red	
3 Suicide 6 Could not be 4 Homicide determined	28e. Piece of Injury - At ho building, etc. (Specify		et, fectory, offic	Се		28f. Location (Str. City or Town,		er or Rura	l Route Number,
29a. Certifier (Check only one) Cartifying Phys	sician: To the best of my knowner: On the besis of exercinet and menner steted.	vledge, deeth o ion end/or inve	occurred et the estigation, in m	time, date en y opinion, dee	d place, th occur	end due to the cered et the time, de	use(s) and me te end plece,	enner es s and dua te	tated. the ceuse(s)
29b. Signature en IIII of certifier	1			ensa number	7 /	29	d. Data signe	d (Month,	Dey, Year)
20 Nome and address of	jn	77)		-/397	//		71	1/7	0
30. Neme end eddress of person who do Robert L. Kaufman		, , , , ,		reet 1	Fred	erick, M	arvlan	d 217	701
21 Date filed (Month Day Year)	20 Davidendo Simos	141					J Chil		-

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical **Examiner**

Funeral Director

deeth with the Meryland

parmit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Merylen Depertment of Health end Mentel Hygiene.
Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Evanither must be notified at once.

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

31. Dete filed (Month, Day, Yeer)



DHMH 16 Rev 6/95

AND A TIME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				State of Mary		rtificate of			Reg. No.	10329					
ľ	Physici		1. Decedant's Name (First, Middla, Last) Ronald Herbert	Wright				2. Data of Dea Month March	14, Dey 1998	3. Time of Deeth 5:31 P.M					
	/Medic Examir		4a. Fecility Neme (If not institution, give s	treet end number)			4b. City, Town, or Lo	cation of Deeth	4c. County of	Deeth					
			Frederick Memoria	1 Hospital			Frederick		Frede	rick					
	Funeral Director		214-42-28/9	7. Age (lr	n yrs. last birthdey) 54 Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Deta of Birth (Month, Day April 8	y, Year) 3, 1943	Birthpleca (Stata or Foraign Country) D . C .					
	ehow ed at	J.	Usual Residence of Decedent 10e. State 10b. County Maryland 10b. County		c. City, Town or Lo Keymar					10d. Inside City Limits 1 ☐ Yas 2 🖔 No					
	the N	ect	10e. Street and Number			10f. Zip Coda			10a Citizon of Miles		_				
	with a or	급		1 .					10g. Citizen of Wha						
	eath 23	era	12815 Woodsboro Pi	. K.C. 2. Was Decedent Eval	rin II S 13	21757	dispends Origin? (Spe	ocify Yes or No-	U.S.	A . Amarican Indian.	_				
21215-0020	i within 72 hours after death with the Maryland ilene. I than "naturel", or items 23a or 28a' show the Modical Examinet must be notified at	by Funeral Director	1 Nevar Merried 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 Yes 2 No If Yes, Give Year or Detes:		if Yes, specify Cub 1 ☐ Yas 2 ☐ No	dispenic Origin? (Spe an, Mexican, Puerto Specify:	Rican, atc.)	Bleck, Specify:	White etc.					
0	2 hou	P	15. Decedent's Educ	ation	16e. Dece	dent's Usuel Occup	pation	T	16b. Kind of Busin		-				
215	hin 7	Completed	(Specify only highest grede Elemantary/Secondary (0-12)	College (1-4or 5+)	(Giva	kind of work done DO NOT use retire	during most of worki	ng							
21	d with	E O	12	College (1-401 37)	Fa	rmer			Farm	ing					
P	should be filed withind Mental Hygiene. merked other than imetic event, the M	Be	17. Fether's Name (First, Middle, Last)				18. Mothar's Nema	(First, Middle,	Meiden Sumeme)	ne)					
<u>a</u>	should be nd Mental merked of urmetic ev	To	Herbert B. Wright				Irma Hirst								
Maryland	d 2 should be filed with th and Mental Hygiene. 7 is marked other than traumetic event, the M		19e. Informent's Neme/Reletionship (Typ.	e, Print)	19b. Maili	ng Addrass (Street	end Number or Rura	il Route Numbe	er, City or Town, St.	ata, Zip Code)					
	of Health Itam 27 other tr		Anthony Balderas (1281	5 Woodsbo	oro Pike,	Keymar,	, MD 217	57					
ore	ges 1 t of H If Itan or oth		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Re	amovel from State	20b. Plece of Dispo cemetary, cra	osition (Neme of metory or other pla	ce)	Dete	20c. Location - Cl	y or Town, Stete					
E	nit. Pag artment ortant: I injury o		4 Donetion 5 Other (Spenish	NIIOVEI II GIII OLELE	Smithsbu	rg Cremat	tory 3	17/98	Smithsbu	g, Maryland					
Baltimore,	pemit. Pages 1 and Department of Health important: if Item 27 any injury or other tr 2006.		21. Signature divineral Service License	Du			DAILEY & H MARKET S								
			23a. Pen1. Enter the disaase, or compile shock, or heart failura. List only on	ations that caused the						Approximate Intervel Between					
	Physician		Onset end Deeth												
	/Medical		Immediata Causa (Final diseese or condition	The	LIMANIL	1				drys					
н	Examiner		resulting in deeth) Dua to (or as a consequence of):												
-	D #	Iner	b												
	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions,	Due	to (or as e conse	quance of):									
90	se ex	<u> </u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury												
68760,	ohys!	edicai	thet initiated events rasulting in death) Last	Due	to (or es e consec	quence of):									
-	15 CD 65		d							i					
Box	eath certi attending I for use a	lan													
	the de	Physician/M	Pert II. Other significant conditions conf	ributing to death but no	ot resulting in the u	inderlying cause gi	ven in Pert I.	23b. Did t	obacco use contr	bute to the cause of death?	?				
P.0	res that the de signed by the a be detached t		Renal Ins	Muen	en			101	Yes 2 No 3	☐ Probably 4 ☐ Unknow	n				
Vital Records,	law requires that the death cert nas been signed by the attendin s 2 should be detached for use	d by	170	00	8			240 18/00	en eutopsy	24b. Were autopsy findings	-				
Ö	v require been sig should t	Completed						perfo	med?	aveileble prior to completion of cause					
Rec	has has	du								of deeth?	4				
<u>a</u>	ician: The certificate h rector, page							101		1 ☐ Yes 2 ☐ No					
Ĭ,		o Be	25. Wes case referred to medical examiner?	ospital:		Ott	26. Pleca of Deetl								
of	F = E	-	1 ☐ Yes 2 ☐ No	12 Inpatient 28a. Data of Injury	2 ER/Outpetie	nt 3LI DOA	4 LI Nursing Ho		ience 8 Other	(Specify)					
O	ding After fune	tlon	1 Neturel 5 ☐ Pending	(Month, Day Ye	ear) Injury	Wo	rk? Yes 2 □ No								
Division	deati deati ctor: y the	Certification:	3 Suicide 6 Could not be	28a Place of Injury	- At home farm st			28f. Location (5	Streat and Number	or Rural Route Number,	-				
Š	or A after Direction	ertil	4 ☐ HomicIde determined	28a. Plece of Injury - building, etc. (S	Specify)	root, lactory, office		City or Tox			П				
_	poltal ours ours filled		29a. Certifier 1/1 Certifying Physics	Ictan: To the bast of m	v knowledna daat	h occurred at the ti	ma date end place	and dua to the	causa(s) and mann	er as stated	-				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai		er: On the basis of exe	amination and/or in	vastigation, In my	opinion, daeth occurr	ed et the time,	dete end plece, en	d due to the ceuse(s)					
	of the office of	Me	29b. Signet re end title of certifier			29c. Licens	se number	Month, Day, Year)	- 4						
	- s - ö		De Stale	Dn	D26516 MARCH				78						
		1	30. Name end address of person who cor	moleted cause of death	/ltem 23a) /Tuna		0 3.			1 15 199	U				
			MI ST / SI	N 1475	TIME 1	AV &	FILED W	>)	1702						
	Sta	te	31. Dete filed (Month, Day, Yaar)	32. Registrer's		Livi	, , , , ,								
	Registr	100	1/3D 1 m 10	1		-									

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

_					ary raine /	Certificate		Death		Reg. No.	10	330				
П	Physic	ian	Decedent's Name (First, Middle, Las	")					2. Date of De Month	ath Day	Year	3. Time of	Death			
d	/Medi		CURTIS RAY WEI						March	12, 1	1998	5:02	PM			
	Exami	ner	4a. Facility Name (If not Institution, give		_		- 1	4b. City, Town, or			y of Death					
L		, III	Frederick Memoria	-		W 1 4m - 4 - m	1 1/2	Frederi		Frede	_					
	Funerai Director		5. Social Security Number 6. Security Number 220-09-7897 Usuel Residence of Decedent	7. Age	9 (In yrs. last bi	rthday) If Under Months	Days	if Under 24 Hrs Hours Min		th y, Year) , 1920	9. Birthple Counti Mary	land	or Foreign			
	and **		10a. State 10b. County		10c. City, Tow	m or Location					10	d. Inside Ci	ity Limits			
	the Maryl 28a-f sho	Director	Maryland Frederic	ck	Thurmo		0-4-		T	40- 000-		1 🖾 Yes	2 No			
	s 23e or	erai Dir	505 East Main St				178				S.A.					
21215-0020	72 hours after death with the Maryland "natural", or items 23s or 28s-f show idical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorcad	12. Wes Decedent I Armed Forces? 1 K Yes 2 □ N If Yes, Give Year or Dates:	⊌ WWII Korea	1 □ Yes 2	⊠ No			Specif	ca - America ack, White, e fy: Whi	etc.				
5-0	be filed within 72 ho itel Hygiene. Id other than "natur event, tre Medical	Completed	15. Decedent's Edu (Specify only highest grad	ication le com <i>pleted)</i>	16a	. Decedent's Usual (Give kind of work life. DO NOT use	Occup	ation during most of wo	rkina	16b. Kind of B	lusiness/Indi	ustry				
121	filed within Hygiene. ther than *	mpi	Elementary/Secondery (0-12)	College (1-4or 5	+)											
	il Hygie other ti		12 17. Father's Name (First, Middle, Last)			Postal	Ca		400	U.S. Governme						
Maryland	2 should be finance and Mentel His marked officers aumatic ever	To Be	Curtis Ray Weddle					Beulah	me (First, Middle, Marie T	roxell						
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. informant's Name/Relationship (T) Patricia M. Weddle		50)5 East M	ain	Street,		el Route Number, City or Town, St Thurmont, Maryla						
ore			20a. Method of Disposition 1 □ Cremetion 3 □ F	Removal from State	20b. Plece o cemete	f Disposition (Nam ry, crematory or oti	e of her plac	00)	Date	vn, Stete						
Ë	Pages ment of I ant: If Ite		4 Donation 5 Dother (Specify)	tomoval from State	Blue F	Ridge Cem	ete	ry	3/14/98 Thurmont, Maryland							
Baltimore,	permit. Page Depertment of Important: If eny Injury or once.		21. Signature of Furgeral Service Licourt	ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788												
			23a Bert Enter the disease, or come	idifficient flat daysed	the death. Do	not enter the mode	of dyin	ALN STRE	ET, THUR	MONT, M		Approximete Interval Bet	ie .			
	Physician		shock, or heart failure. List only o	ne office on eastylin	4	,					i l	Interval Bet Onset end I	ween Deeth			
å	/Medical		Immediate Ceuse (Finel disease or condition	CIM	aint	1 h	14.	1 +	milum		1	2/2	1			
	Examiner		resulting in deeth)		Due to (or es e	consequenca of):,			or Toyor			year	4			
-	70 ##	iner			war	ant	116	du	nan		- 1	Exta	11			
	and trens	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underfying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Due to (or as a consequenca of): Due to (or as a consequenca of): 1													
60,	be ex cian buriel	a E														
68760,	rificete be executed ng physician and es the buriel-trensit	g														
Вох	5 D 0	an/Me														
	deat	sicis	Part II. Other significant conditions con	ntributing to death bu	t not resulting la	n the underlying ca	use giv	en in Part I.	23b. Did 1	obacco use co	ontribute to	the cause o	of death?			
% P.O	requires that the death ce seen signed by the attendii hould be detached for use	by Phy	Enployera						10	Yes 2□ No	3 Probe	ably 4 🗗	Unknown			
Records,	aw 2 s	Completed t	, ()							an autopsy med?	com	re autopsy fi llable prior to apletion of c eath?	0			
E	The law ate has b	20							101	es 2000	10	Yes 2	No			
/ita	Physicien: The this certificate ral director, par	Be	25. Was case referred to medical examiner?						ath (Check only o	ne)						
of Vital	00	ို	TE Yes 2LUANO	lospitel: 1 Depatier			-	4 U Nursing F	Home 5 ☐ Resid			-				
ב	When unen	ion	27. Menner of Deeth 1 ☐ Naturel 5 ☐ Pending	28a. Dete of Injur (Month, Day	Year) 28b.	, ,	c. Injun		28d. Describe h	now Injury occur	red					
Sic	Attending or death. actor: After by the fune	cat	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not be			М		Yes 2 No	005.1							
Division	To the Hospital or Attending Phi within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	4 Homicide determined	28e. Pleca of Inju building, etc	ry - At home, fa (Specify)	rm, street, factory,	offica		28f. Location (S City or Tox	Street and Numi m, State)	ber or Rural i	Route Num	ber,			
	n 24 hou	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examination	sician: To the best of ner: On the basis of and manner stat	examination en	o, deeth occurred a d/or investigation, i	t the tin	ne, dete end plece pinion, death occu	e, end due to the curred et the time,	cause(s) and m dete and place,	anner as sta and due to t	ited. the cause(s	;)			
	To the	Σ	29b. Signeture end title of certifier	110		29c.	License	e number		29d. Date signe	d (Month, D	ay, Year)				
)			30. Name and address of person who co	Autoleted cause of de	WSh ath (Item 23a)	(Type Print)	1	1771		3//61	9					
			Lloyd E. Halvorson			Avenue,	Ere	ederick	Marulan	d 21701						
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		11	CACITON	Haryrall	u_61/VI						
	Registr	ar	MAR 1 7 19	98 Juli	Murilean	P.										
DHI	MH 16 Rev 6/9	5		1)		- ANDREW										

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. No. 9		331		
	District of		1. Decedent's Neme (First, Middle,	Last)				· · · · · · · · · · · · · · · · · · ·	2. Dete of De	eeth	Yeer	3. Time of Death		
	Physici /Medic			Henry H	I. Wood	field			March	Dey 15	1998	7:10am		
	Examir		4e. Fecility Neme (If not institution, g					4b. City, Town, or						
			Holy Cross Hosp	ital				Silver S	pring	Mon	tgome	gomery		
	Funeral			. Sex 7. A	ge (In yrs. lest	birthdey)	if Under 1 Year Months Deys	If Under 24 Hrs	8. Dete of Bir	th		lece (Stete or Foreign try)		
	Director		219-12-2672	10XM 2□ F	74	Yrs.	Workins Deys	Hours Will.		5, 1923		yland		
	P.		Usuel Residence of Decedent		T									
	show	-	10e. Stete 10b. County		10c. City, To						10	Od. Inside City Limits		
	M Par	5	Maryland Montgo	omery	Koc	kville	2					1 ☐ Yes 2 ☑ No		
	or 2	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of Whet Country?				
	23m		14515 Carrolton	Road			208	53		Americ	an			
	tem tem	Funeral	11. Meritei Stetus	12. Wes Deceden Armed Forces	?	13. We	es Decedent of res, specify Cul	Hispenic Origin? (S ben, Mexican, Puer	specify Yes or No to Rican, etc.)	- 14. Rac Blac	e - America ck, White, a			
20	S afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	WWII	10	Yes 2 No	Specify:		Specify	Whit	re		
Ş	hour	D D	1000000	Yeer or Dates:		O- Dd-	- 11 1 0 1							
21215-0020	n 72 ned	Completed	15. Decedent's (Specify only highest of	rede completed)	11	(Give kii	nt's Usuel Occu nd of work done O NOT use retin	during most of wo	rking	16b. Kind of Bu		ustry		
7	with than	E	Elementary/Secondary (0-12)	College (1-4or 2	5+)		ident			Corpo		n		
O	Hyg Hygen	Ö	17. Fether's Neme (First, Middle, La					18. Mother's Ner	me (First, Middle	, Maiden Sumen				
au	id be ental	To B	Bradley M. Wo	odfield				Maria						
ary	and M	-	19e. Informent's Name/Reletionship	(Type, Print)	1	9b. Mailing	Address (Stree	t end Number or Ru	ural Route Numb	er. City or Town.	Stete. Zip	Code)		
Σ	ulth a		Mary D. Woodfie	ld - Wife				Lton Road						
altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hyglena. Important: if Item 27 is marked other than "naturel", or Items 23a or 23a-f show any injury or other traumatic event, the Macical Examiner number routined at once.		20e. Method of Disposition		20b. Place	of Disposit	ion (Name of		Dete	20c. Location -	City or To	wn, Stete		
E 0	Page ento rt: IT I		1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe				tory or other ple Methodi	st Cemete	ry 3/18	Damascu	s. Ma	arvland		
	ortar		21. Signeture of Funeral Service Lice				Name end Addr					-		
ä	Depariment Department Importment Importment Importment Inc.		VOL. Y-TIM	V. T.	h	01:	in L. M	olesworth	, P.A.,	Funeral	. Home			
			23a. Pert1. Enter the disease, or d	molications that cause	ed the deeth. D	264	+01 Rid	ge Road,	Damascı	us, Mary	land	20872-01 Approximate		
	Physician [®]		23a. Pert1. Enter the diseese, or c shock, or heart failure. List of	ly one cause on each	line.		,		, , , , , , , , , , , , , , , , , , ,		ļ	Interval Between Onset end Deeth		
	/Medicai		Immediate Cause (Final								ì			
	Examiner		disease or condition resulting in deeth)	e. Aspira	tion Pr						i			
_		ner		Carahr	Due to (or es		ance or): Accident				1	5 Davis		
	rificate be axecuted ng physician and as the burial-transit	Examiner	Sequentially list conditions	b. Celebi			1	-				5 Days		
o,	axec an an rial-tr													
68760,	ysicié	Wedical	Cause (Disease or Injury thet Initiated events are detailed a consequence of):											
	5 0 0	Ped	resulting in deeth) Lest											
ROX	eath cer attendin	N/N		d										
	deat	sici	Pert II. Other significant conditions	contributing to death	but not resulting	g in the und	erlying cause g	iven In Pert I.	23b. Did	tobacco use coi	ntribute to	the cause of death?		
J.	law requires that tha death ce as been signed by the attendi o 2 should be detached for use	Physician/I							10	Yes 2 No	3 Prob	ably 4 🖾 Unknown		
	gned be de	by												
Records,	v require been si should I	g							24a. Wes	en eutopsy	ava	re eutopsy findings alleble prior to		
ပ္မ	has be	ple									of o	npletion of ceuse leeth?		
	The late has page	Completed							1 🗆	Yes 2 No	1□	Yes 2K No		
VIII		Be	25. Was case referred to medical					26. Place of Dec	eth (Check only	one)				
-	Physician: rthis certific rral director,	To	exeminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpat	ient 2 ER/	Outpetient	3 DOA	ther: 4 Nursing H	lome 5 ☐ Resi	dence 6 □Oth	er (Specify	')		
DIVISION OF	g Ph		27. Manner of Deeth	28e. Dete of Inj (Month, De	ury 28t	o. Time of Injury	28c. Inju	iry et	28d. Describe	how injury occur	red			
Ö	ath. Ar: Af	atic	1 ☑Netural 5 ☐ Pending investigat	ion	, ,	,,]Yes 2□No						
ž	tel or Attending Ph rs after death. al Director: After th ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of In	ijury - At home, tc. (Specify)	, ferm, stree	t, factory, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rurel	Route Number,		
	rs aft	Cer			,,					,				
	Hospital 24 hours 2 Funeral staly filled	edical	29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Phyalcian: To the best	of my knowled	lge, deeth o	ccurred at the t	ime, date end plece	e, end due to the	cause(s) and ma	inner es sta	ated. the ceuse(s)		
	a the	Med	one)	end menner s	tated.									
	S S S	-	29b. Signeture end title of certifier	41	-0	0		se number		29d. Dete signe				
			Marke	of ducex	real	T		4646		March	15, 1	1998		
			30. Name end eddress of person wh	o completed cause of	deeth (Item 23)	e) (Type, Pr								
			Martin S. Rosen	thal M.D.	10810	Connec	ticut A	lve, Kens	ington,	Marylan	d 2	0895		
	Sta Registr		31. Dete filed (Month, Day, Year) MAR 1 6	1998 " Jel	rar's fignetare	orker	all.							

DHMH 16 Rev 6/95

STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CERTIFIC	CATE OF	DEATH	REG. N	0.	
	1. DECEDENT'S NAME (First, Middle, Last)	Δ -	4	-1		2. DATE OF DEATH		3. TIME OF DEATH
	LEANA ADIA	JA HGAN	d			MONTH	8 9	8 1112p M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In y		IF UNDER 1 YEAR	IF UNDER 24 HRS,	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
		1 M 2 F	YRS.	ONTHE DAYS	HOURS MIN.	(Month, Day, Year)	8 r	nary/and
	9e. FACILITY NAME (If not institution, give str	reet and number)		b. CITY, TOWN O	R LOCATION OF D		9c. COUNTY	
<u>ا</u> ۳	Prince George	s Hospital (PAREN	Cherry	111		Prin	0 -
15	RESIDENCE OF DECEDENT	- 1100/110	9117	ज : पुष	7		10000	ac o cages
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATI	ON			10d. INSIDE CITY LIMITS?
0	rnd trinc	e Georges	Neu	CATA	ollton			1 PYES 2 NO
	10a. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?
FUNERAL	11737 Mixerdal	a Road		12	0784		45	
5	11. MARITAL STATUS INFONT	12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2				NIC ORIGIN? (Specify)	es or No- 14	. RACE — American Indian,
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 IF YES, OIVE WAR OR DATE	2 NO		2 TO Specif	in, Puerto Rican, etc.) y:		Black, White, etc. Specify: (7)
		INFONT						DOCK
TE	15. DECEDENT'S EDUC (Specify only highest grade of		le. DECEDENT'S US (Give kind of wor	k done during mos		16b. KIND OF B	USIHESS/INDUS	TRY
Į jų	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	retired.)				
COMPLET	+M+cmT	infant	1040	mt		INF	ant	
E 8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S HA	ME (First, Middle, Meide	n Surname)	
B g	THEYOR OKIN	MUAND			LEAH	ANTHA	ACA	rd
examiner must be notified at once. TO BE COM	19a. IHFORMANT'S NAME (Type/Print)		196. MAILING AT	AI A	d Number or Rural	Route Number, City or To	wn, State, Zip Co	
9 7	LEAH MURRO		11/21	Kiverda	the Rd	New CAN	rolltan	md 20784
<u> </u>	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Temporary		ACE AND DATE OF		100h	~ -245 A 395	OCATION - CIO	y or Town, State
Ĕ	4 Donation 5 Other (Specify)		y, or other or other	141	SUBTO	DO WY	now	, DC
흹	21. SHOWATURE OF FUNERAL SERVICE UN	PISEE / 11/.		22, NAME AND	D ADDRESS OF FA	CILITY	- NI	1 11 1
	- ASONY IN	concer-		HM(3017 x	CANA.	DA UM	Arely MYXXXXX
	23. PARY i. Enter the diseases, or ci	ompileations that caused th	a death Do not	anter the mod	la of dulog aug	901011		and only
2	shock, or heart failure. L	List only one cause on each	Ilna.	1	ie or dynig, add	ii aa cardiac or iga	on actory arrest	Approximate interval Between
2	disease or condition	A	1	- B				Onset and Death
E.	resulting in death)	DUE TO (OR AS A CO	anu	ely				
3		AND TO JUN AS A CO	PRINCE OF):	T				
or other traumatic event, the medical	Sequentially list conditions,	DUE TO (OR AS A CO	HREQUENCE OF	~				
TA F	if any, leading to immediate cause. Enter UNDERLYING	202 10 (011 110 11 00						
들은	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF:					
	resulting in death) LAST		,					i
	- 0	le						
물	PART II. Other aignificant conditions	a contributing to death but r	not resulting in	the underlying	cause given in		N AUTOPSY	24b. WERE AUTOPSY FINDINGS
DICAL CI						1 YES	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
병교						_ ' ' ' ' '	2 (1)	OF DEATH?
\$ 12 2	DID TOBACCO USE CONTR	BUTE TO CAUSE OF I	DEATH YES	D NO IZ	TINCEPTAIL			1 TES 2 HO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH		OTTCLKIAII	10		
SIC!	EXAMINER?	HOSBITAL:	_ 0	THER:				
E K	27. MANHER OF DEATH	28e. DATE OF INJURY	28b. TIME C			8 Other (Specify) 28d. DESCRIBE HOW	MANUEL COOLIE	
	1 Haturel 5 Pending	(Month, Day, Year)	IHJUR	Y WOR	ES 2 NO	200. DESCHIBE HOW	INJUNY OCCUR	SED
	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY —	At home form etre		E3 2 NO	201 1 2 2 1 2 2 1 2 1	-5	
ZS IS	4 Homicide B Could not be determined	building, etc. (Specify)	At troine, term, ette	ret, ractory, ornica		28t, LOCATION (Stree City or Town, Stet	end Number or i	Rural Route Number,
	29e, CERTIFIER							
COMPLETED	(Check only	CIAH: To the best of my knowledg	je, death occurred	at the time, date a	and place, end due	to the cause(s) and m	inner as stated.	
	2 MEDICAL EXAMINER	R: On the beals of examination an	id/or investigation,	in my opinion, de	ath occured at the	time, data and place, e	ind due to the c	euse(s) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1	~		29c. LICENSE NUI	ABER	29d. DATE S	IGHED (Month, Day, Year)
	May	11. Ccon	ww.		0	33593	▶ 7	425/98
5	30. NAME AND ADDRESS OF PERSON WHO		ITEM 27) (Type, Pr	iat	-			1
	(RA-16	S. CROPI	P. W	V9>	4	6 Na	A A	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATU	RE YOU JUDG			140	Turk	~
J	0.0 1000	guia Davidsol	-yanaeac				*	

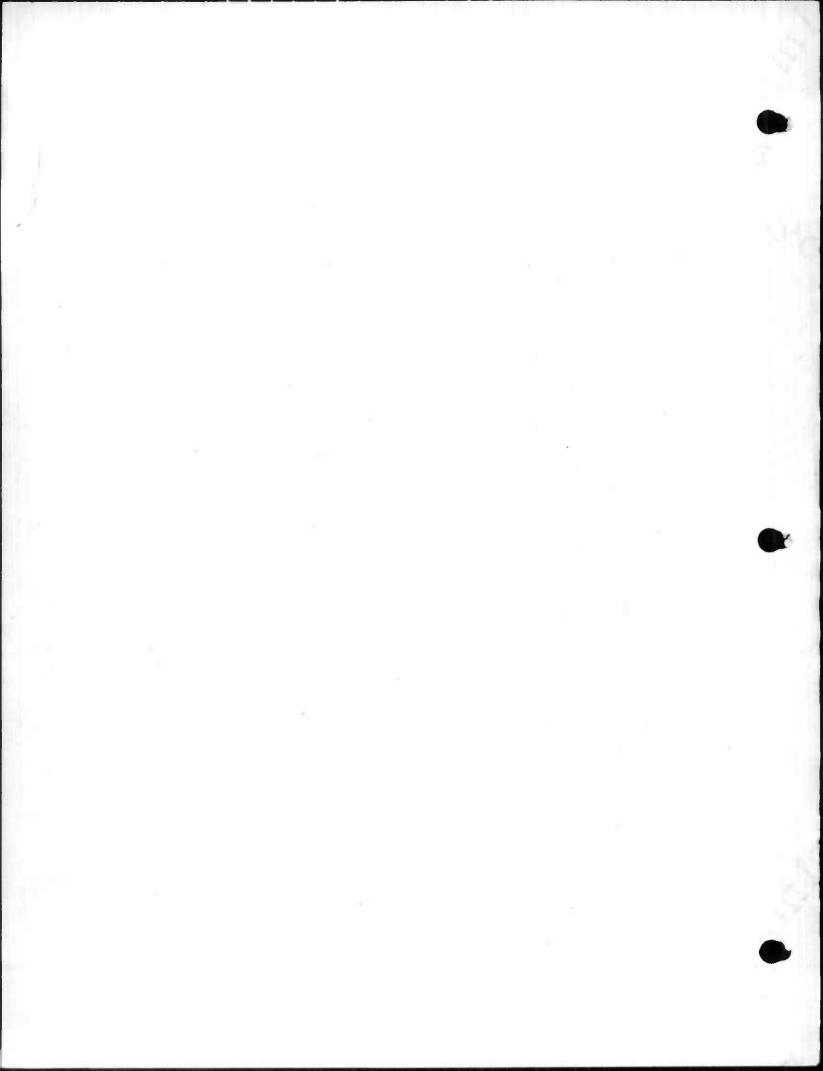
DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TS hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

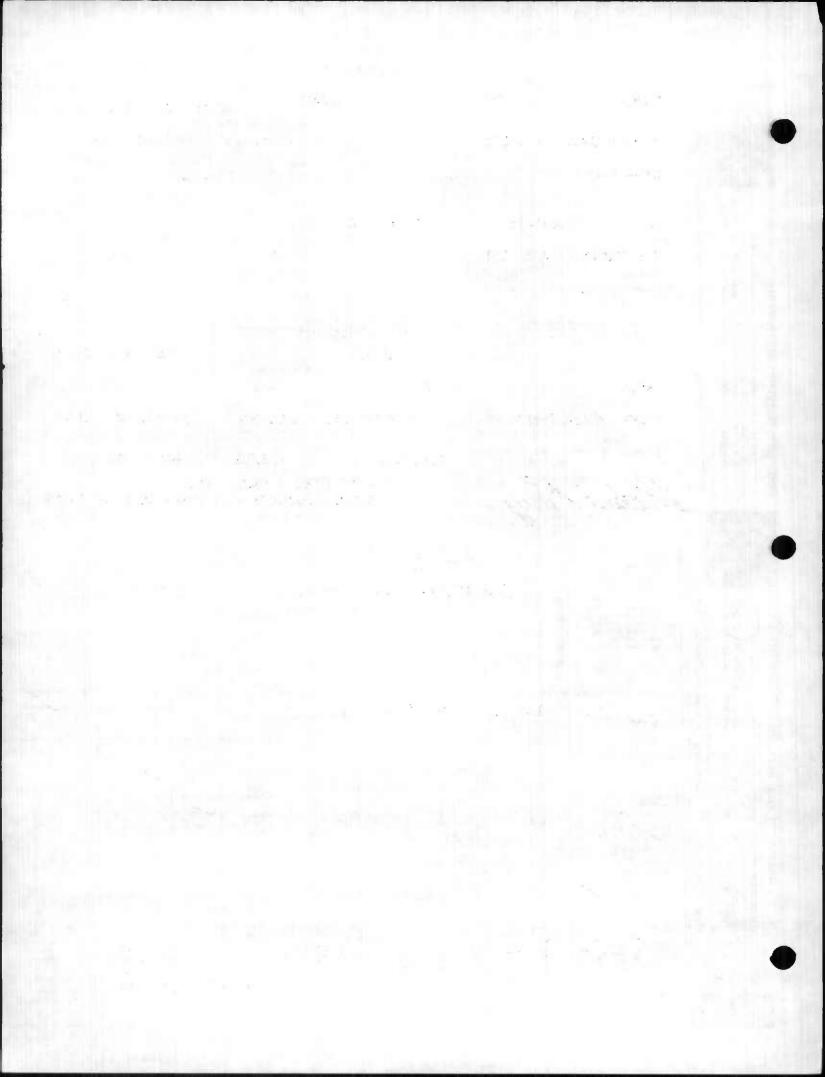
DHMH-16 Rev 1/89



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month HOWARD LEE ADLER **Physician** MARCH 30 1998 8:10 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner 7 SLADE AVE., APT. 301 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Deys 1 M 2 □ F Yrs. 213-07-8394 79 **Director** JUNE 20,1918 MARYLAND Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 7 SLADE AVE., APT. 301 21208 USA permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Bedical Examerae means Funerai 14. Rece - American Indian. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) ARTIST DISPLAY BUSINESS 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be maserow ADLER HARRY MARY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) RENEE ADLER (WIFE) 7 SLADE AVE., APT. 301 21208 BALTO., MD Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 4/1/1998 OHEB SHALOM BALTIMORE, MD of Funeral Services Licege 22 Name and Address of Facility BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Pent1. Enter the disease, or complication that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest shock, or heart feiture. List only operations on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner accident Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of) law requires that the deeth certificat P.O. Box signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of degih? 1 Yes 2 No 3 Probably 4 hknown Division of Vital Records, 2q 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed ils certificate has I 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 ☐ Accident the Funeral Director filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, death occurred at the time, date end pieca, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Main 50 Reisterstown 132 Registrar's Signators 31. Dete filed (Month, Dey, Year) APR 02 1998 State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth March **Physician** 11:17 am Anginette Boone /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. APRIL 7) CHURCH HOME HOSPITAL If Under 1 Year 9. Birthplace (State or Foreign Country) HARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 200 F 36 Yrs. Months Deys 213-72-3485 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIHORE CIT 1 Yes 2 No Directo MARYLAND 10e. Street and Number Og. Citizen of What Country? 1619 PATTERS ON PARKAGE USA. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, 2 10 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A FETERIA WORKER BALTO, CITY SCHOOLS 12 THGRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be MORRIS BOONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 鱼 (MOTHER) 1619 N. PATTERSON PARK AVE, BALTO, ND. 21213

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Item 27 VLESTER BOONE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removel from State ING MEMORIAL PARK 4-2-98 Baltim WOODLAWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part 1. Enter the disease, or complications that count the death. Do not enter the mode of dying, such as cardiac or respiratory furrest.

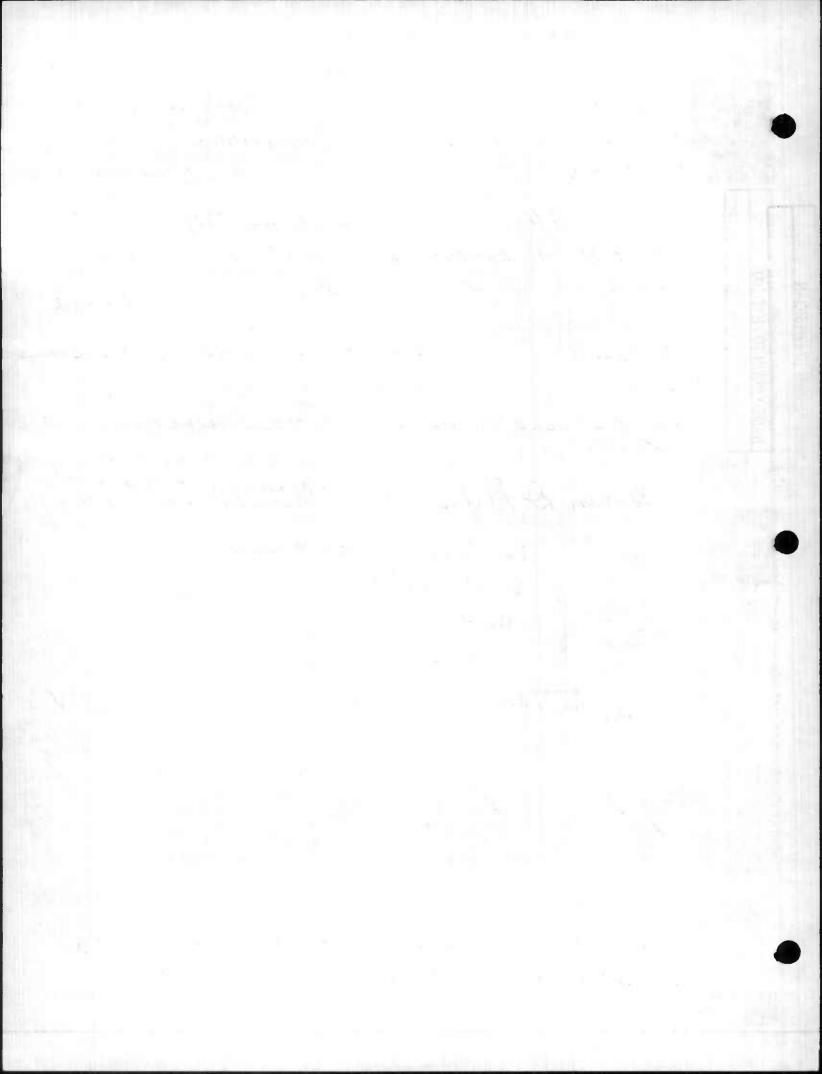
Approximate **Physician** . Probable Coronary Heart Disease /Medical Immediate Cause (Final diseese or condition resulting in death) **Examiner** Diabetes Mellitus Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Hypertension Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was en autopsy performed? Be Completed 1 Yes 2 No 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification by the funeral director, I 25. Wes cese referred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■Inpatient 2 □ ER/Outpatlent 3 □ DOA P 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day Yeer) 28c. injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D. eoge E. Wills W. March 28, 1998

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Frint)

George E. Wicks III 100 North Broadway 32. Registrer's Signeture Julia Davidson Randalle APR 02 1998



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

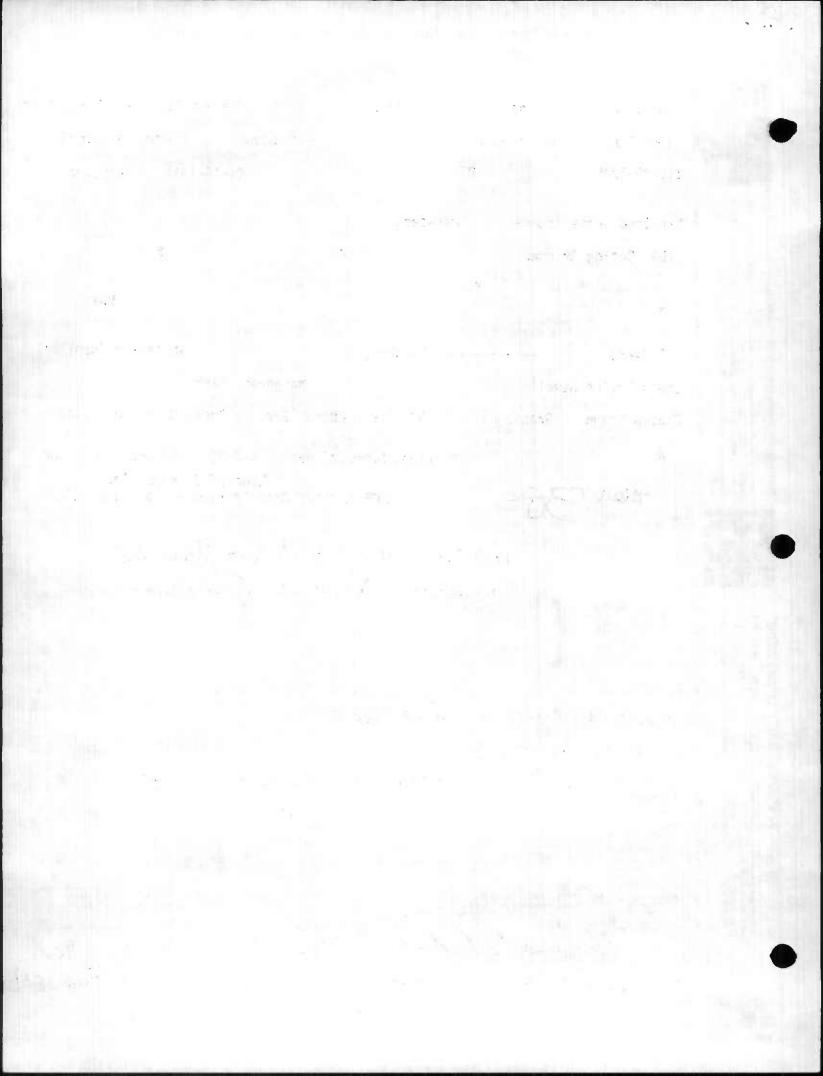
Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 30, 1998 6:29 AM March Brown Martha /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner Pasadena Anne Arundel Oak Lodge Senior Home | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01-16-1911 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F 212-20-7389 87 Yrs. Maryland **Director** Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Pasadena Maryland | Anne Arundel 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number Pages 1 and 2 should be filed within 72 hours after death with it in the filed half Media Hydiana. This in a filed of the filed half filed 23 a or 3 filed the traumatic event, the Medical Exercities may be in yor other traumatic event, the Medical Exercities may be in U.S.A. 21122 7753 Outing Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Wholesale Supplier Bookkeeper 12 Years 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Margaret Fink Louis Taylor Hewell 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
390 South Drive Severna Park, Maryland 21146 19a. Informent's Name/Relationship (Type, Print) (Grandson) Steven Brown 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Buriat 2 Cremation 3 Removal from State permit. Pege Department important: If any injury or Moreland Memorial Park 4-4-98 Baltimore, Maryland 22. Name and Address of Fecility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee mailsT. 5305 Harford Road Baltimore, Maryland 21234 23a. Part1. Enter the disease for complications that caused the deeth. Do not enter the mode of dying, auch es cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset end Death Physician HYPERTENSIVE HEART DISEASE /Medical Immediete Cause (Finel diseese or condition resulting In deeth) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in deeth) Lest Division of Vital Records, P.O. Box 6876 Physician/Medical physical the bur Due to (or as e consequence of) 80 USB Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by the 6 d be detached f 23b. Did tobecco use contributs to the causs of death? 1 Yss 25 No 3 Probably 4 Unknown INFARCT LACUNAR by 24b. Were autopsy findings aveileble prior to 24e. Was an autopsy Completed OSTEOPOROSIS completion of cause of death? COMPRESSION FRACTURES THORACIC 1 Yes 2 DNO 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 410 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No ^oL funerei 28e. Dete of Injury (Month, Dey Year) 28b. Time of 27. Mannes of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homtcide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie 29c. License number DO 25/9 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) CRAIN TOWERS KICHARD ISHETC

32. Registrer's Signature

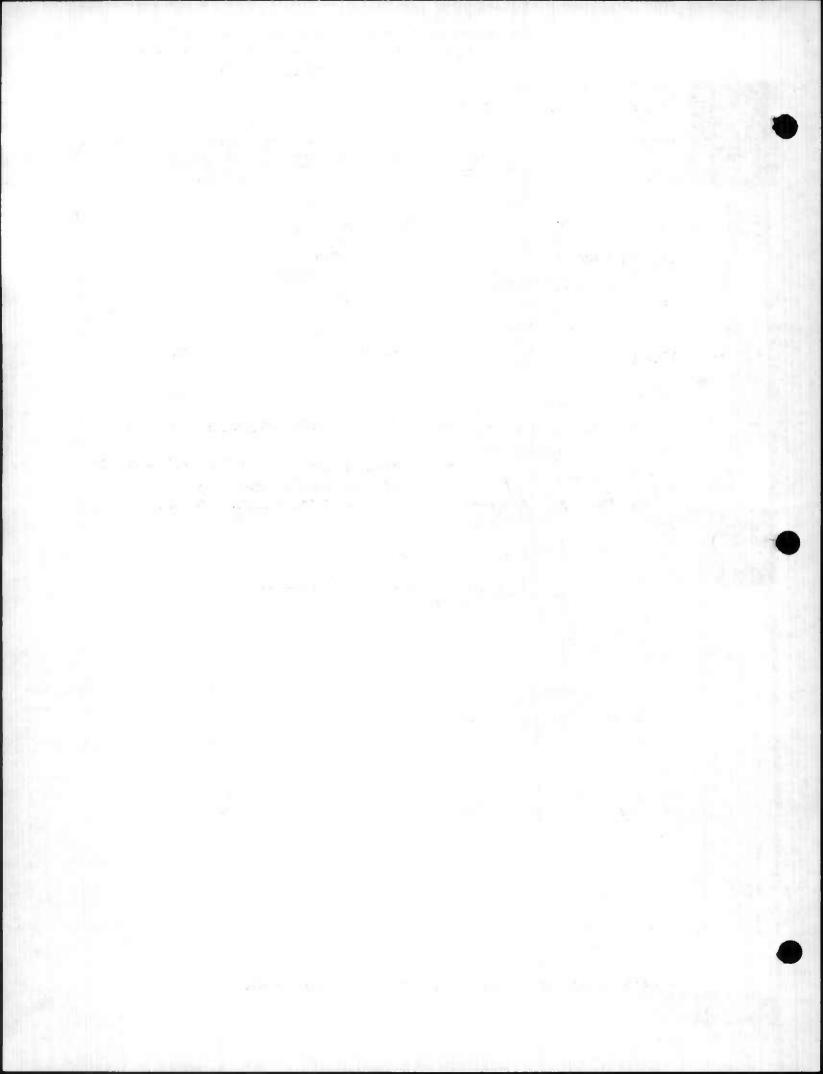
DHMH 16 Rev 6/95

Registrar



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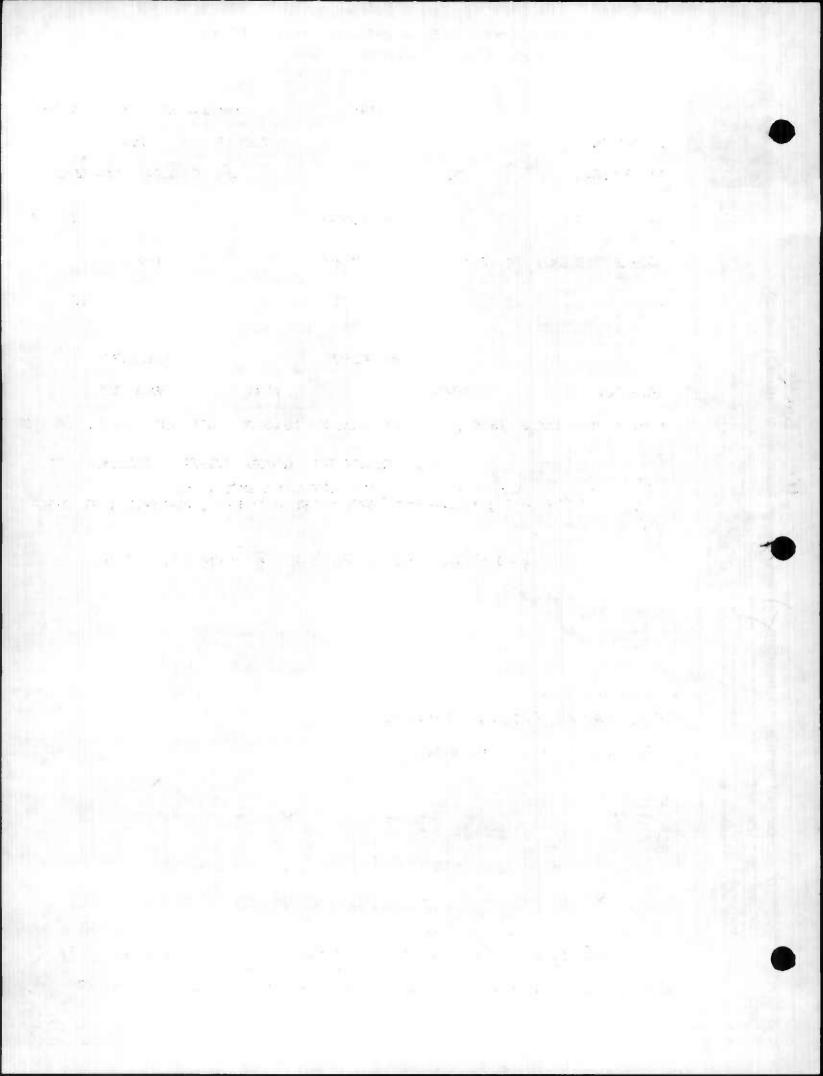
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П	Physici	an	Decedent's Neme (First, Middentification)						2. Dete of Dea Month	th Dey	Yeer 3	3. Time of Death
	/Medi			MIENTUS BURG				44 (0) 14 (0) 14	APRIL			9:00 A.M.
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-	P	-	5318 TILBURY 5. Social Security Number		ga (In yrs. las	t birthday)	If Undar 1 Year	BALTIMOR If Under 24 Hrs.			N/A	e (State or Foreign
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	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of \	What Country	?
	23a	rai	5318 TILBURY	WAY			2121	.2		USA	¥.	
21215-0020	be filed within 72 hours after death with the Marylen tal Hygiene. d other than "naturel", or flems 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	?		Was Decedent of I f Yes, specify Cub I□ Yas 2∑No	Hispanic Origin? (Span, Mexicen, Puerto Specify:	pecify Yas or No- Rican, etc.)		e - Amarican I ck, White, etc. /: WHT	
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Maryland	ntal H	Be o						18. Mother's Nam	ie (First, Middle, I	vielden Sumen	ne)	
2	should be and Mental s marked o umatic eve	2	JOSEPH ORSZU 19a. Informant's Name/Relation			19h Mailir	on Address (Street	KATE end Number or Ru		KNOWN	State Zin Co	v/a)
Z			DOLORES M. WIL				TILBURY		TIMORE,			00)
altimore,	permit. Peges 1 end 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumetic QDCS.		20e. Method of Disposition	LIAMSON DAU	GHTER 20b. Piac	e of Dispo	sition (Name of netory or other ple			MD 21 20c. Location -	212 City or Town,	, State
E	Pege ent o nt: If		UD Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (-						1/6/98	PHILAD	ET DUTA	Dλ
alti	pemit. Pe Departmer Important: any injury		21. Signalure of Funeral Service	Licensee	HOL	22	ULCHRE C . Name end Addre	ess of Facility			PPEUTW	/_FA
m	Depared Important Important Inches		& Lea He.	11. Hours				UNERAĹ HO I RAVEN BI			230	06
	7117		23a. Enter the disease, of shock, or heart feilure. Lis		d the death.	Do not ent	er the mode of dyi	ng, such as cerdiac	or respiratory err	NSON, M	; Ap	oproximate terval Between
	Physician		, 51.51, 51.51	<u> </u>		. 1						nset and Deeth
	/Medicai Examiner		immediate Cause (Finel diseasa or condition resulting in death)	Conge	stive	Diea	ut Fa	cline			6	Zyrs
Н	Examine:	1	resulting in death)	0	Due to (or a	s e conseq	juence ol):))			0
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	ificete be executed g physician and es the burial-transit	Exal	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury		Due to (b) as	s e conseq	uence ol):					
68760,	e be rsicla	edicai	that initiated events	C	Dua to (or as	9 000000	uence of):					
	E 000		resulting in death) Lest		Dua to (or as	a conseq	derice or).					
Box	th cer tendir r use	Physician/M		d								
0.	he at	sici	Part II. Other significant condit	ons contributing to deathy	out not resultin	ng In the ur	nderlying ceuse gi	ven in Part I.	23b. Did to	obacco use co	ntribute to the	e cause of death?
. P.O.	The law requires thet the death cert ate has been signed by the attendin pege 2 should be deteched for use	by Phy	Chamie.	Kenal Fo	reluce	دد			1□ Y	08 2 X NO	3 Probab	ly 4 ☐ Unknown
Records,	w requires thet been signed t should be det	Q De							24e. Was e	n eutopsy	24b. Were	autopsy lindings
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Viita		BeC	25. Was cese referred to medical	ai				26. Plece of Dea	th (Check only or			
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0	Attending ir death. octor: After by the fune	catic	2 Accident invest	igetion		,,		Yes 2 □ No				
Division of	or Att after of Direct	Certification:	3 Suicide 6 Could 4 Homicide deten	nined 286. Plece of In	jury - At home ic. (Specify)	, larm, str	eet, factory, office		28l. Location (Si City or Town		per or Rural Ro	oute Number,
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	To the Nospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29e. Certifler (Check only one) 12 Medical	ng Physician: To the best Examiner: On the basis of end manner st	examination	age, death and/or inv	occurred at the ti restigetion, in my o	me, dete and place, opinion, deeth occur	and due to the c red et the time, d	ause(s) and ma ete and place,	anner as state and due to the	d. e ceuse(s)
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			30. Name and address of persor	who completed ceuse of	deeth, from 23	Ba) (Type.	Print)					
			STUART BROGER					302 BALTI	MORE. MC)		
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	Registr	ar	APR 02 1998	Junavan	racon-than	· Joseph						



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State of Maryland / Department of Health and Mental Hygiene

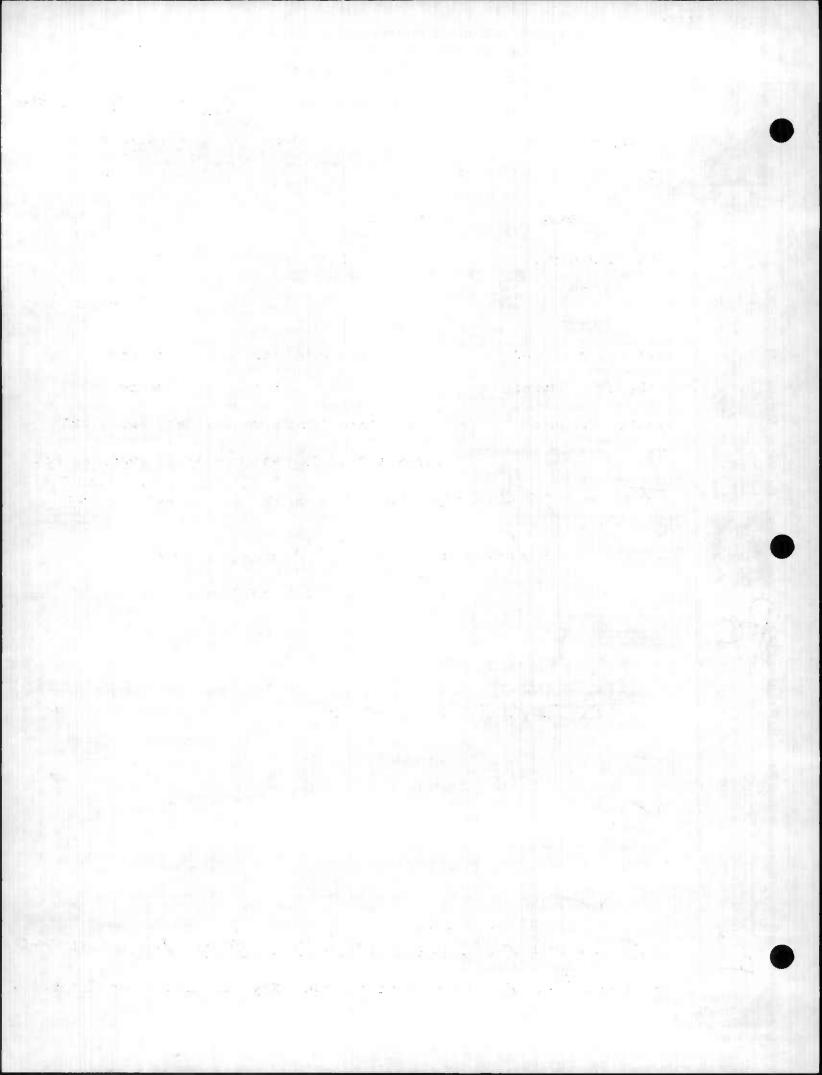
Certificate of Death 3. Time of Deeth 2. Date of Death 1 Decedent's Name (First Middle Last) Day Month **Physician** 6AM BARK MARCH 26 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner LEVINDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Months Yrs. 214-20-5642 JAN 16, 1904 MARYLAND **Director** Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be nortified at 1 Yes 2 No N/A BALTIMORE Director MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6514 EBERLE DR., APT. 204 21215 USA death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. In 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1□ Yes 2√ No Specify: Specify: WHITE p 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) KASNETT ANNA **EDLAVITCH** BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Health in Ham 27 I MRS. BARBARA SACHS (DAUG.) 7203 ROCKLAND HILLS DR., APT. 412 BALTO., MD 21209 altimore, Important: If ham any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removel from State
Donation 5 Other (Specify) MIKRO KODESH BETH ISRAEL 3/29/98 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. eurs 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Enter the diesese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) . END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): edical Due to (or es a consequence of) Physician/M 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ARTERY CORDNARY DISEASE Division of Vital Records, ğ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed HYPERTENSION ASTHMA complation of cause of death? 2 9080 certificate has 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28e. Dete of Injury (Month, Day Year) 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 8 24 hours a Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) Within 2 To the å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING Extestin PHYSICIAN MARCH 26 0 25610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SET HTWAR BALTIMORE LEVINDALE WEST BELVERDERE AVENUE MI) 21215 2434 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State APR 02 1998 Registrar



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State of Maryland / Department of Health and Mental Hygiene

				ertifica	te of	Death	Re	g. No. 98		1338	
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Examiner	4a Facility Nema (If not institution, give	street and number)				4b. City, Town, or L	ocation of Death	4c. County		- 13 -	
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neral ector	5. Social Security Number 6. Sa 217-34-5615 Usual Rasidance of Dacedant	7. Age	(In yrs. last birtho	Month:	ar 1 Yaar 3 Days		8. Data of Birth (Month, Day, O8-14		9. Birthpla Countr Md.	aca (Stata or Forai ly)	gn
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Medical Examiner	disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that Initiated events rasulting in death) Last	С	Due to (or as a con	nsequance o	·):	Cardi.	282				
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n: To Be	27. Manner of Beath	28a. Date of Injury	28b. Tin	ne of	28c. Inju		28d. Dascribe ho				
tior	1 Natural 5 Pending invastigation	(Month, Day	Year) Inju	M M		ork7]Yas 2∐No					
Certification:	2 Accidant Invastigation 3 Suicida 6 Could not be determined	28e. Place of Injur building, atc.	ry - At homa, farm (Specify)	, streat, facto	ory, office		28f. Location (St. City or Town		er or Rural	Routa Number,	
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Me	29b. Signatura end titla of pertifiar		>	2	9c. Licen	se number	25	9d. Data signa	d (Month, E	lay, Year)	
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	20 Name and address of the second	inimalate d account of	VOUNCE	ma Pitri)	ne	1201	963	/ KI	101	-11/1	
	30. Nama and addrass of person who o										
	Dr. Charles Do	nnell, M	D Villa	age o	f Cr	coss Key	s 111 H	amlet	Road	Apt.4	08
State	31. Data filad (Month, Day, Year)	QQQ 32. Registrar	Signature	~ Randa	22						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No: 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 3 John DEEMS 22 98 3:00 AL DAMNARD /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KOCKFLEET Rd Timonium BAITIMONE 201 TENN If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months Døys 1X M 2□ F Yrs. 87 Oct. 26, 1910 Maryland Director 220-09-9673 Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Timonium Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 404 Rockfleet Road, Unit 201 21093 USA Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 11. Maritel Status nit. Peges 1 and 2 should be filed within 72 hours after carment of Health and Mertal Hygiene. ortant: If Item 27 le marked other than "natural", or ite injury or other traumate event, the Med call Examina 1 Never Married 2 Narried 1 N Yes 2 No If Yes, Give Specify: White 1 Yes 2 No Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Law Lawyer 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Lydia Headly Joshiea Soul Barnard 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Rockfleet Road, Unit 201, Timonium, MD 21093 Margaret S. Barnard/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Pege Department of Important: If eny Injury or pace. Balto. Wash. Crematory Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 3/23/98 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Michael J. Flagle, per DVR Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final HYPEPTENSIVE CARDIOVASCULAR DISEASE FEW YEARS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the Due to (or as a consequence of): 88 ettending esn requires that the death Po signed by the e 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen page 2 hes 1 ☐ Yes 2 No 1 Tyes 2 No certificate or Attending Physician: funeral director. 25. Wes case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home & Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: 1 Matural 5 Pending s efter death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 | Homicide 24 hours e Funerel C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai within 24 hor To the Fune completely fi (Check only one) the 29d. Date signed Month, Day, Year) 29b. Signature and title of cert 29c. License number D 45039

Registrar

State

30. Neme end eddres

William

31. Date filed (Month, Day Near)

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on who completed cause of deeth (Item 23a) (Type, Print)

32. Register's Signature

JACKSON

1998

9105 Franklin Square

BAITO, MD

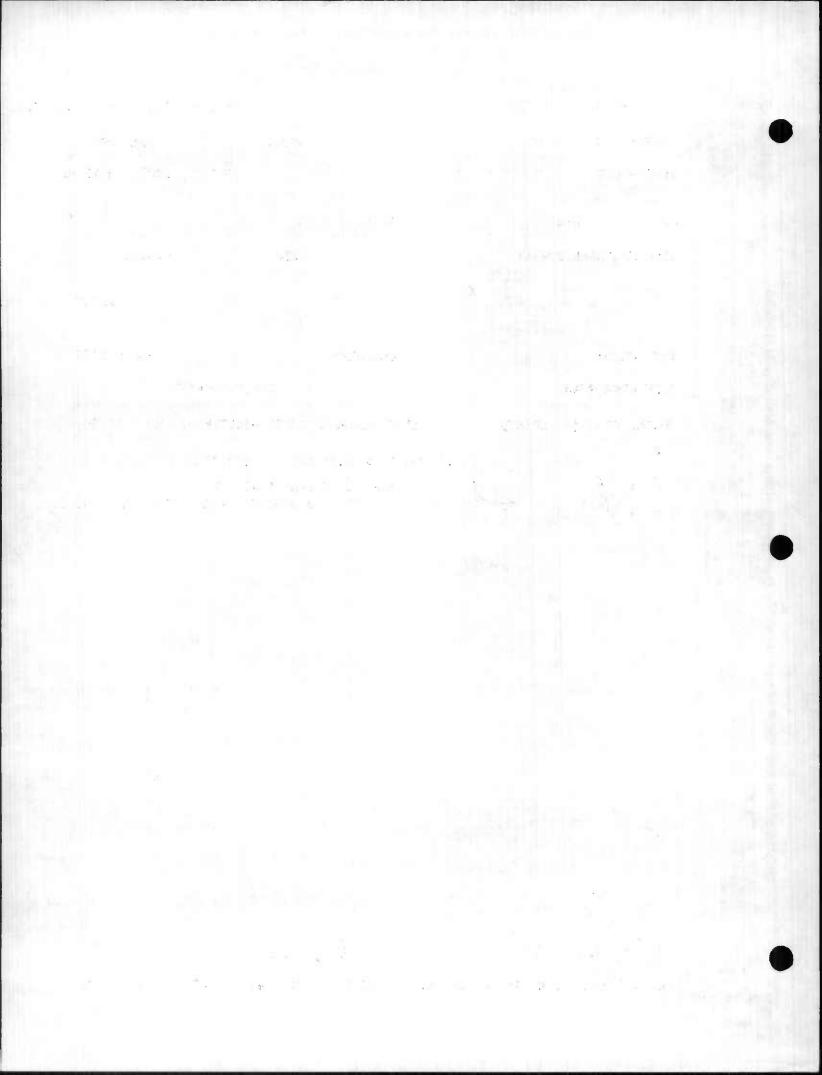
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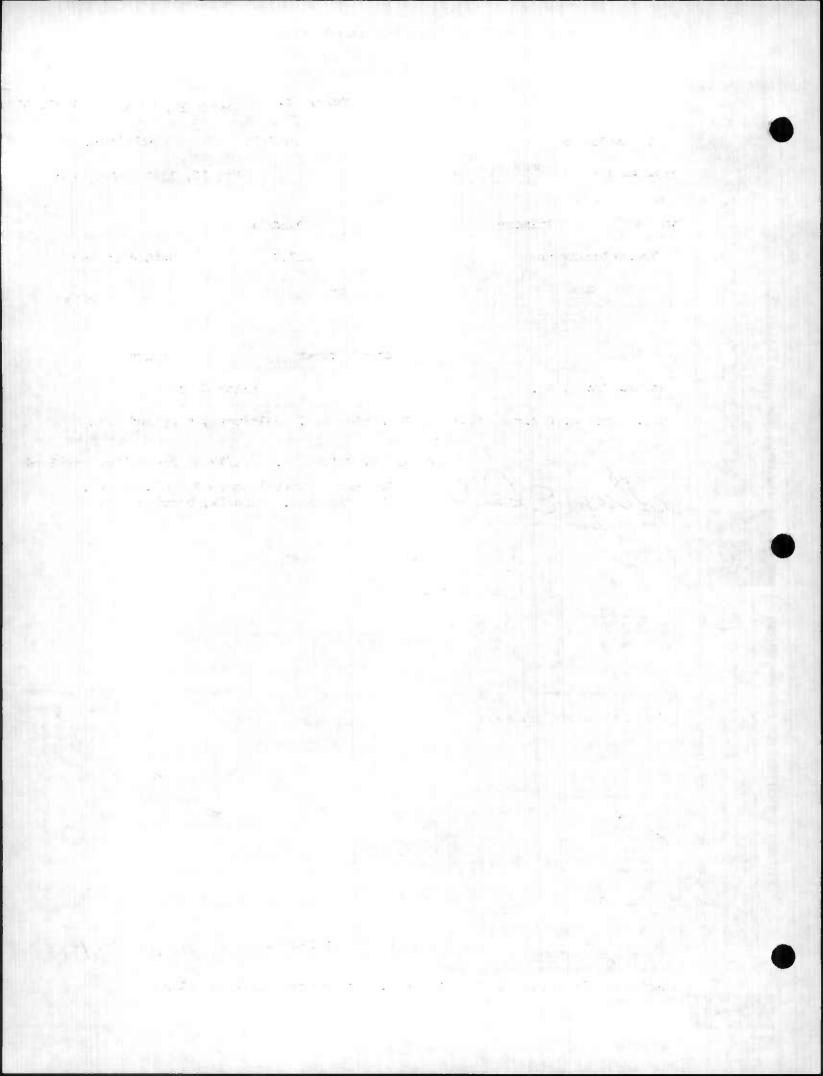
	Certificate of Death		9. No. 9	0340									
A	1. Decedent's Name (First, Middle, Last)	2. Data of Death Month		3. Time of Death									
Physician /Medica	CORINNE A.M. BACHMAN	MARCH	27, 1998	3 11:45 P.M.									
Examine	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death	4c. County of Det	nth									
	MANOR CARE - RUXTON TOWSON		BALTIN										
Funeral Director	5. Social Security Number 216-09-2027 Usual Rasidence of Decedent 6. Sex 1 M 2 DRF 90 7. Age (In yrs. lest birthday) Yrs. 1 Months Days Hours Min.	8. Data of Birth (Month, Dey, JULY 21,	Year) 9. Bi	nthpiaca (Stete or Foreign country) ARYLAND									
Pu M	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits									
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h with	1508 MARSHALL STREET 21230		U.S.A.										
Ind 21215-0020 be filled within 72 hours after death with the Manyland lat hyglene. I dother than "natural", or items 23s or 28s-f show event, the Madical Exprise must be incuffed at the Completed by European Director.		ecify Yas or No- Rican, etc.)	14. Race - Am Black, Wh Specify:										
Phou Phou	15. Decedent's Education 16a. Decedent's Usual Occupation	1	16b. Kind of Business										
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hyglene. The merked other than "natural", or traumatic event, the Medical Event	(Specify only highest grada complated) (Giva kind of work done during most of work life. DO NOT use ratired) Elamantary/Secondary (0-12) College (1-4or 5+)	ing											
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should be	JOHN LEMMERMAN ELSI	E DeGRAI	FT										
2000	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rura	el Route Number,	City or Town, Stete,	Zip Code)									
e, N 1 and 1 and Heaith Wher tr	HOWARD SNOW (GUARDIAN) 1508 MARSHALL STREET-E			230									
S - E	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date 2	20c. Location - City o	r Town, State									
Fag ment:	4 Donation 5 Other (Specify) LOUDON PARK CEMETERY	3/31/98	BALTIMOR	RE									
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other to	21. Signature of Funeral Service Licensea 22. Nama and Address of Facility HUBBARD FUNERAL HOME 107 WILKENS AVENUE 23a. Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of the death of the disease of the death. Do not enter the mode of dying, such as cardiac of the death of the dea	- BALTI	MORE, MD	21229 Approximate Interval Batween Onset and Death									
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8 3 3	Cause (Diseasa or injury that Initiated events resulting in death) Last Due to (or as a consequence of):												
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Of Vita Physician: this certific ral director.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Ho	ma 5 Raside	nce 6 Other (Sp	ecify)									
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Division of Vital To the Hospital or Attending Physician: T within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p	Z	28f. Location (Sti City or Town	raat and Number or i , Stata)	Rural Route Number,									
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1	(Denice 009831		3/30/	78									
16	30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)	TOUCO	N MD 2	1204									
State	DR. ANDERSON M. RENICK - 7600 OSLER DRIVE - SUITE 401 31. Date tiled (Month, Dey, Year)	- 10M20	II, III. Z	1204									
Registrar	APR 0 2 1998 Juna Paridoon Randale												



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State of Maryland / Department of Health and Mental Hygiene 9 8 | 0 3 4 |

			Ce	ertificate	of Death		Reg. No.	10	071			
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/Medical		noward		CL			h 29, 199	8	10:30 2			
Examiner	4a Facility Neme (If not Institution, given	re street and number)			4b. City, Tow	n, or Location of De	eath 4c. County	of Deeth				
	78 Avalon Ave	nue		Dundalk Baltimore								
Funeral			s. last birthday	/) If Under 1 \	Year If Under 24	4 Hrs. 8. Dale of (Month,	Birth Day, Year)	9. Birthplac	ce (State or Fore			
Director	213-28-8118	1 2 M 2□ F 66	Yrs.	MONITS	ays Hours	May :	16, 1931		land			
2 2	Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or L	ocation				10d	I. Inside City Lim			
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or 2844 si be notified Director	10e. Street and Number			10f. Zip Co	ode		10g. Citizen of \	Whet Country	/?			
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r items 23s	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	U,S. 13	Wes Deceden	t of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No- 14. Rac	ca - American				
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th and Meni T is marked traumatic	Howard Craig, S					Mildred						
and and and and and and and and and and	19a. Informant's Name/Relationship			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Avalon Ave. Baltimore, Maryland 21222								
or other tr	Mrs. Carol A. C	3				altimore,	-					
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page 2 should to						24e. W	les en autopsy erformed?	comp	e autopsy tindin able prior to pletion of cause			
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Be Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Deeth (Check or						
To all din	1 Yes 2√No	1 inpatient 2	ER/Outpeti		4 LI NUR	-	esidenca 6 Ott					
on char	27. Manner of Death 1∠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		Injury et Work?		be how Injury occur	100				
ector: Ahe by the fune iffication	2 Accident investigation			М	1 Yes 2 N							
Bec T	3 Sulcide 6 Could not to determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, s	street, factory, o	ffica	28f. Location	n (Street and Numi Town, Stete)	ber or Rural F	Houte Number,			
within 24 hours after To the Funeral Din completely Illed in Medical Cert	29a. Certifier 1 Certifying Pl	nysician: To the best of my ki niner: On the basis of exami and manner steted.	nowledge, dea neti <i>on</i> end/or l	ath occurred at investigation, in	the time, date and my opinion, death	place, end due to	the cause(s) and m ne, dete and placa,	anner es stat and due to t	ted. he cause(s)			
Me Me	29b. Signature end title of cegtifier	and married stated.		29c. L	icense number		29d. Dete signe	ed (Month, Dr	ey, Year)			
348	29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Yea BL 3146506 March 30,19											
10	Aleghan	ce Linaer	_ M)	01400		March	, 20,	1118			
	30. Name and address of person who	completed cause of death (It	em 23a) (Type	e, Print)								
1	Stephanie Linder	,MD 2801 Fos	ter Av	e. Bal	timore,	Maryland	21224					
State	31. Dete filed (Month, Day, Year) APR 0 2 199	32. Registrar's Sig		1								
Registrar	APR 0 4 193	18 Juna Dai	4dson-10	ndell								



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EN	CROWTHE	R	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9 1 0 3 4 2													2
		1.	Decedent's Name (First, Middle	, Last)							2. Date of				3. Time of	f Death
и	Physician				Aller	,	Cros	vther			Month		ay	Year		
	 /Medical 	4.0	Facility Name (Mast Institution				020	V C.11C.1		4b. City, Town,		h 27		of Death	2:.	15PM
	Examiner	r 40	Facility Neme (If not Institution									Delta!				
L			61 Wise Avenu		Apt.			If Under	1 Voor	Dund		D: 45		ltimo		-
	Funeral		Social Security Number	6. Sex 1 XM 2		ge (In yrs. las	of birthday) Yrs.	Months	Days	Hours M	in. (Month,	Day, Yea	ir)		lace (Stete o	
	Director		215-56-1271			48	118.				Feb.	8,19	50	Balt	imore	, MD
	pu »	-	sual Residence of Decedent la. State 10b. County			10c City	Town or Lo	nation						1	0d. Inside C	iby Limite
	72 hours efter death with the Maryland natural; or items 23a or 28a-f show dies Examiner must be notified at the figures of Directors.					Too. Ony,	TOWN OF EO	oution.						- 1		2 🔯 No
	M o M	M	aryland	Baltin	nore						Dundal	1			14E 13	
	ih th	10	e. Street and Number					10f. Zip	Code			10g. 0	Citizen of	What Cour	at Country?	
	ifter death with the Ma r items 23a or 28a-fe inter must be notified	100	61 Wise Avenue	Apt	t. B					21222		Un	ited	Stat	es	
	dea	11	. Maritel Status	12. Was	s Decedent red Forces?	Ever in U,S.	13. V	Vas Deced	lent of h	Hispanic Origin? an, Mexican, Pu	(Specify Yes or	No-		ce - Americ		
0	or it		1 Never Married 2 Marri	ed DC	Yes 2	No		☐ Yes 2			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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21	C * 6	1	Elementary/Secondary (0-12)		iege (1-4or	5+)	life. L	O NOT us	e retire	d)	· · · · · · · · · · · · · · · · · · ·					
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pu	きまなる 4		. Father's Name (First, Middle, I	Last)						18. Mother's N	Name (First, Mid	e (First, Middle, Meiden Sumeme)				
<u>a</u>	Mental Mental Srked o	2	Reubin Crowth	er			Doris M. Dougherty									
Maryland 21215-0020	the Figure		e. Informant's Name/Relations	nip (Type, Prin	nt)		19b. Mailin	g Address	(Street	t end Number or	Rural Route Nu	mber, Cit	y or Town	, Stete, Zip	Code)	
	trate and a		Nancy Barrett		Siste	er	15 W	aterv	iew	Road H	Baltimor	e. M	arvl	and	21222	
ē,	- I E E	20	a. Method of Disposition			20b. Ple	ce of Dispo	sition (Nen	ne of		Dete	7		- City or To	wn, State	
Baltimore,			1 Buriei 2 Cremetion		from Stete		netery, cren				/+ 000					
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	40240		1 rege	m C	.100	س		7922	Wise	e Ave.	Dundalk	Ma			1222	
п		2	Sa. Part1. Enter the disease or shock, or heart failure, jist.	compilcations	thet ceuse e on each i	d the death.	Do not ente	er the mod	e of dyi	ing, such as cerd	diac or respirator	ry arrest,		1	Approxima Interval Be	tween
	Physician													į	Onset and	Death
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Record	has b	2									INS	PECT	ION	of	death?	
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of	S S	2	1∰Yes 2□ No	Hospital:	1 L Inpati	ent 2 El	R/Outpatien		JA		g Home 5 ☑ F				(y)	
	ding Ph. h. After th funeral	27	'. Manner of Death 1 ∰Naturel 5 ☐ Pendin	28a.	Date of triji (Month, De	ay Year) 2	8b. Time of Injury	2	8c. Inju		28d. Descr	ibe how in	njury occu	rred		
010	Attending or death. Sctor: After fune by the fune	all	2 Accident investig	ation	M 1 Yes 2 No											
ivision	or Attending P ifter death. Srector: After in by the funeri		3 Suicide 6 Could r 4 Homlcide determ	jury - At hom tc. (Specify)						28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)						

State Registrar

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

MARCH 31, 1998

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

O.C.M.E.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Stephen Radentz, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 02 1998

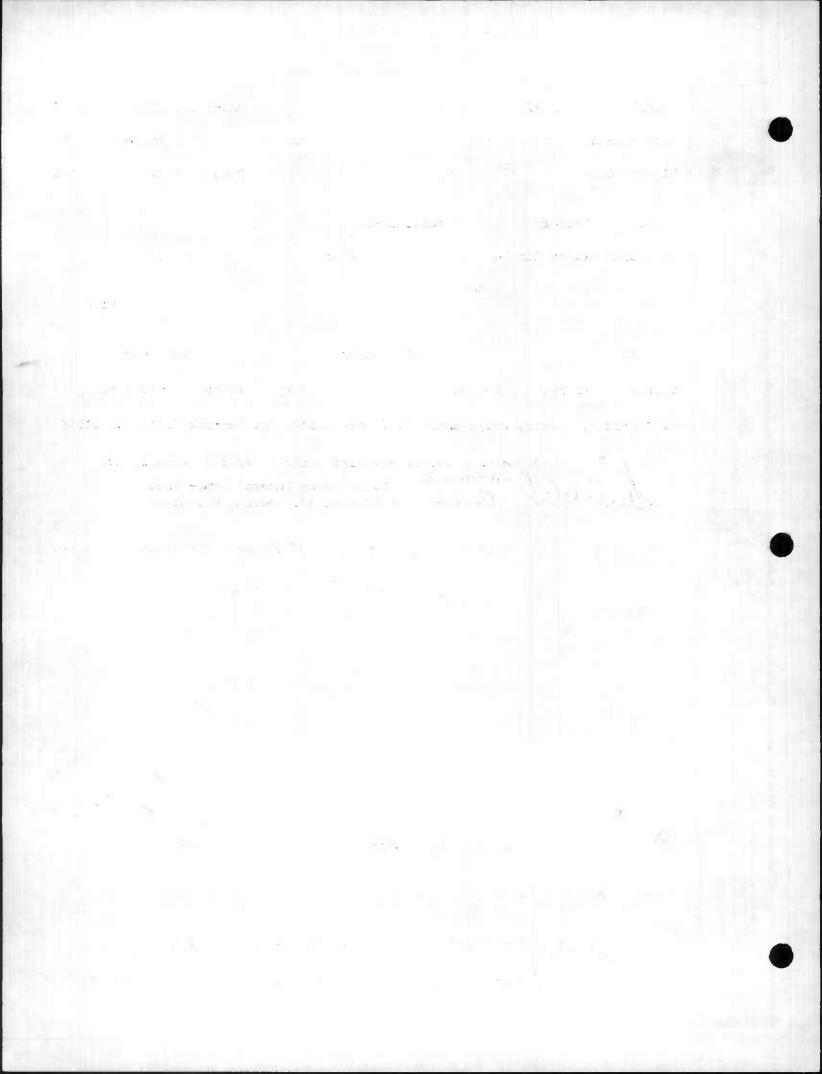
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Month **Physician** GLORIA COSTER March 30, 1998 11:15 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Hart Heritage Nursing Home Harford Street 8. Dete of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Days Hours Min Yrs. 212-10-0025 80 Director June 7, 1917 Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Magical Examinat must be notified at 1 Tyes 2 TXNo Directo Md. Harford Forrest Hill 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 1857 Beth Bridge Circle 21050 IISA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or its 1 ☐ Never Married 2 ☑ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home maker Own home 18. Mother's Neme (First, Middle, Meidan Sumema) 17. Fether's Neme (First, Middle, Last) Be O'Connor Mary 2 Andrew Boston Irene George 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. tnformant's Neme/Reletionship (Type, Print) Mr. Robert Y. Coster, Sr./husband 1857 Beth Bridge Cr. Førrest Hill, Md. 21050 altimore, 20b. Place of Disposition (Nema of cematary, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Nother (Specify)Entombment Belair Memorial Gardens 4 Donation 4/4/98 Belair, Md. STEPHEN D. 22. Name and Address of Facility ervice Licentific Ruck Towson Funeral Home, Inc. 23a. Part l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or implicatory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** CHRONIC GBSTRUCTIVE PULMONAM DISCARE /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Coronpay Artery Disuse Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Lest Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 22 No certificata Hospital or Attending Physician: 25. Was case raferred to medicel examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) CARE Hospital: 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28e. Data of Injury (Month, Dey Year) Certification: 1 Naturel 5 Pending 1 Yas 2 No after death. Director: Aft 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) NA Investigation 2 Accident 6 Could not be datarmined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homloide 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number D39889 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) 615 West MACPHAR RD BelAIR 21014 SPARKES RAD 32. Registry's Signature

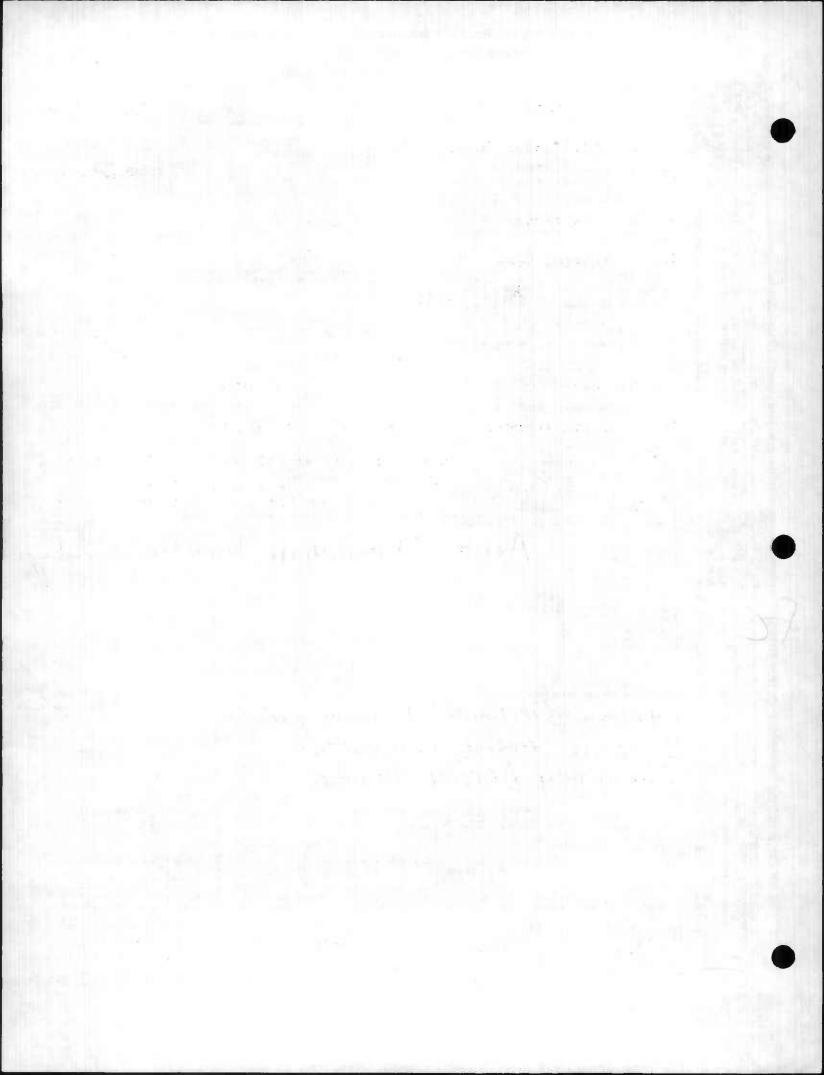
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			•	Certificate	e of Death	Reg	g. No.	10044	
	Di stata	1. Decedent's Name (First, Middle, La.		FIRE INC. TO		2. Date of Death Month	Day	3. Time of D	eath
	Physician /Medical	Jam	es T. Cox			March 3		98 6:30)pm
10	Examiner	4a Facility Name (If not institution, give				Location of Death	4c. County o	f Death	
		Manor Care Ru 5. Sociel Security Number 6. S	xton Nursin	g Center	Tows		Ba	ltimore	
	Funeral		MM 2DF	Tast birthday) If Under Months Yrs.	1 Year If Under 24 Hrs Days Hours Min		Year)	9. Birthplace (Stete or Country)	Foreign
	Director	219-01-4012 Usual Residence of Decedent	86	113.		DEC 25,	1911 101	strict of Col	lumbia
	land	10e. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City	Limits
	the Marylar 28a-f show nout ed a	Maryland Balti	more	Cato	nsville			1 ☐ Yes 2	2 No
	with the Mai n or 28a-f s be notified Director	10e. Street and Number		10f. Zip		10	g. Citizen of W	hat Country?	
	23a o 23a o	540 S. Rolling	Road		21228			USA	
	r kems 234	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I,S. 13. Was Deced	ent of Hispanic Origin? (Sify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		- American Indian, , White, etc.	
20	or h	Never Married 2 Married	1 X Yes 2 No If Yes, Give WW	III 1□ Yes 2			Specify:		
00	72 hours after death with the Maryland natural, or items 23a or 28a-f show older Examination by notified at steel by Funeral Director	3 Widowed 4 Divorced	Year or Dates:					White	
21215-0020	led within 72 ho ygjene. Ner than "naturi nt, tre Medical Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedent's Usue (Give kind of work	l Occupation k done during most of wo e retired)	orking	6b. Kind of Bus Chambe		
212	within ene.	Elementary/Secondery (0-12)	College (1-4or 5+)	Statisti			Commer		
	other vent, by	17. Fether's Name (First, Middle, Last)		Dialisti		ame (First, Middle, Ma			
au	Mental H arked ott atic sver	James Cox			Pear1	Douay			
Maryland	E E E	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address	(Street end Number or Fi	Rurel Route Number,	City or Town, S	itete, Zip Code)	
	alth a 27 is or trat	Mark McDaniel/	nephew	540 S. Rol	ling Road (Catonsvill	e. MD	21228	
ore	of He start of He	20a. Method of Disposition	20b. I	Place of Disposition (Nem	e of			city or Town, State	
Baltimore,	ment my o	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)	y) Mea	adowridge Me	morial Park	4/3/98	Elkr:	idge, MD	
alt	Pepart Pepart Inv Ini	21. Signature of Funeral Servica Licer	See Onal	22. Name and	Address of Facility bb Funera	1 Home	РΔ		
ш	20138	Dawn F. Mc	Donald	301 F	rederick	Road Ba	1timo:	ce. MD 21	228
		23a. Part1. Enter the disease, or com- shock, or heert failure. List only	plications that caused the dear	th. Do not enter the mode	of dying, such as cardia	ac or respiratory arres	st,	Approximete tnterval Betw	reen
F	hysician	The state of the state of	A					Onset and De	eath
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	House	Myoca	ARDIAC	INFA	RUTIO	N; 2da	up
	- T		Due to (or as e consequence of):					(/
2	n and latinansit Examiner		b						V
1	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as e consequenca of):					
36	physics is the bur	that initiated events	C. Due to (c	or as a consequence of):					
. 89		resulting in deeth) Last	200 10 10	or as a consequence ory.					
Вох	attending for use a		d						
	ine law requires mat the deem earth as the been signed by the attending page 2 should be detached for use page 2 should be detached for use page 2 should be Physician/I	Part II. Other significant conditions of	ontributing to death but not res	sulting In the underlying ca	ause given in Part I.	23b. Did tob	acco use con	tributa to the ceuse of	death?
P.0	ed by the detache	CHERRY (DASTRUCTIV	E Pulmo	raper Dis	5A (5 10 Ye	8 2 No	3 □ Probably 4	Inknown
	b bed	GTRONIC S	1	- / Gartor	1.71-9 1013			- 1	
Vital Records,	Vequires that the de been signed by the tangent of the should be detached should be detached interesting the should be should	(HRONIC	ATRIAL	FIBRILL	FIUN	24a. Was an periorm	autopsy ed?	24b. Were eutopsy fir available prior to completion of ca	
ec	nas b e 2 sl		1000	7				of deeth?	000
1	scient: Ine law certificata has b lirector, page 2 s o Be Compli	CORONARI	HRIER	1 MSET	756	1 ☐ Yes	20 No	1 Yes 2 N	10
Vita	ector Be	25. Was case referred to medical examiner?	Hospital:		Othor:	eth (Check only one			
of	this certific ral director,	1 Yes No 27. Megner of Deeth	1 L Inpatient 2L	ER/Outpetient 3□ DO 28b. Time of	A 4 Nursing	Home 5 ☐ Resider			
no	After funer	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	Injury	Bc. Injury at ' Work? 1 ☐ Yes 2 ☐ No	200. 2000100 1101	in injury occurre		
Division	Attending ir death. ector: After by the fund iffication	3 Sulcide 6 Could not be		ome, farm, street, factory		28f. Location (Stre	eet end Numbe	r or Rurel Route Numb	oer,
Ö.	rs after death. al Director: After t led in by the funera Certification:	4 Homicide	building, etc. (Speci	fy)		City or Town,	Stete)		
	to the neepting or attending Physicians: within 24 bours after death. To the Funeral Director: After this certific completely illied in by the funeral director, Medical Certification: To Be (ysicien: To the best of my kno						
	in 24 hour he Funera pletaly lill edical	(Check only 2 Medical Examone)	ninar: On the basis of examina and menner stated.	ation and/or Investigation,	In my opinion, death occ	curred at the time, da	te and placa, a	nd due to the ceuse(s)	
	Within To the Common To the Co	29b. Signature and title of cartifier	1	290	License number	29	d. Date signed	(Month, Dey, Year)	
	_	Jaeveen !	Halelaui		D 2869 2		4/1/98	5	
	1	30 Neme and eddress of person who	completed cause of deeth (Iter	m 23e) (Type, Print)	11-0-1	1 2	11	112 012	0
	0	IASNEEM L	AKHANI, 72	20 PARK	HEIGHTS F	Tro 121	400	11) 2420	8
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign						
	Registrar	ALK A C 1236	golia David	son-Aandall					

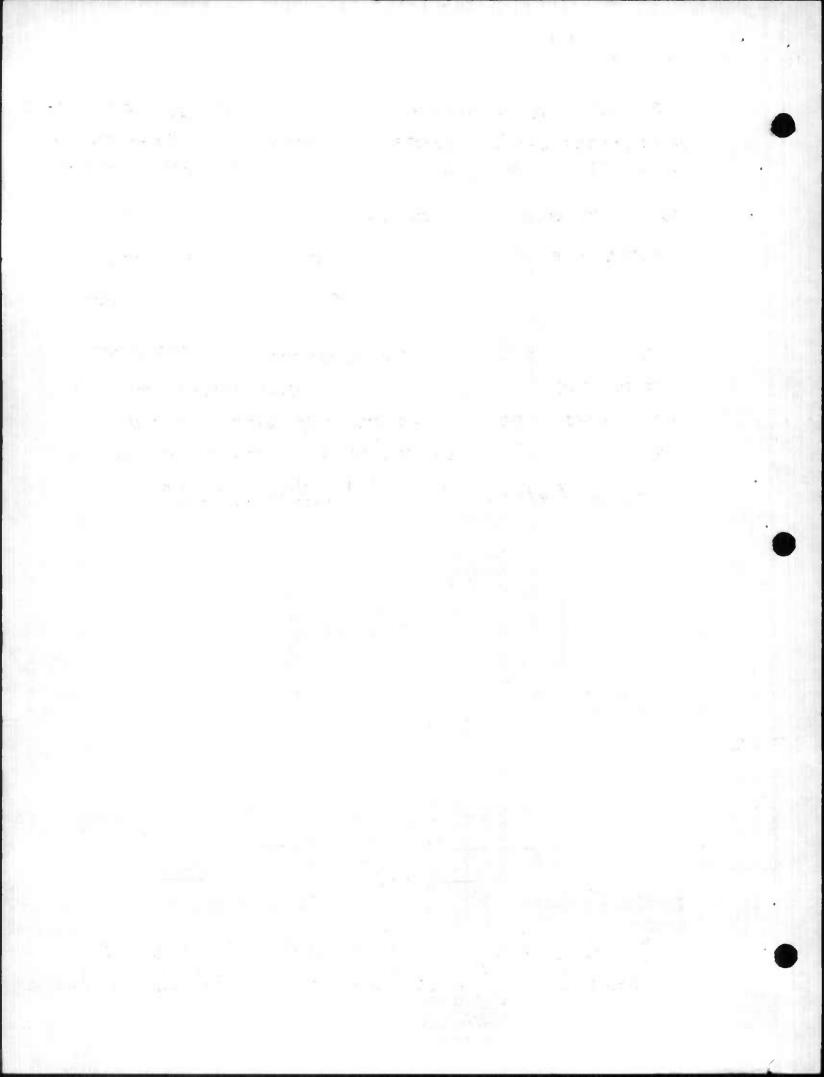
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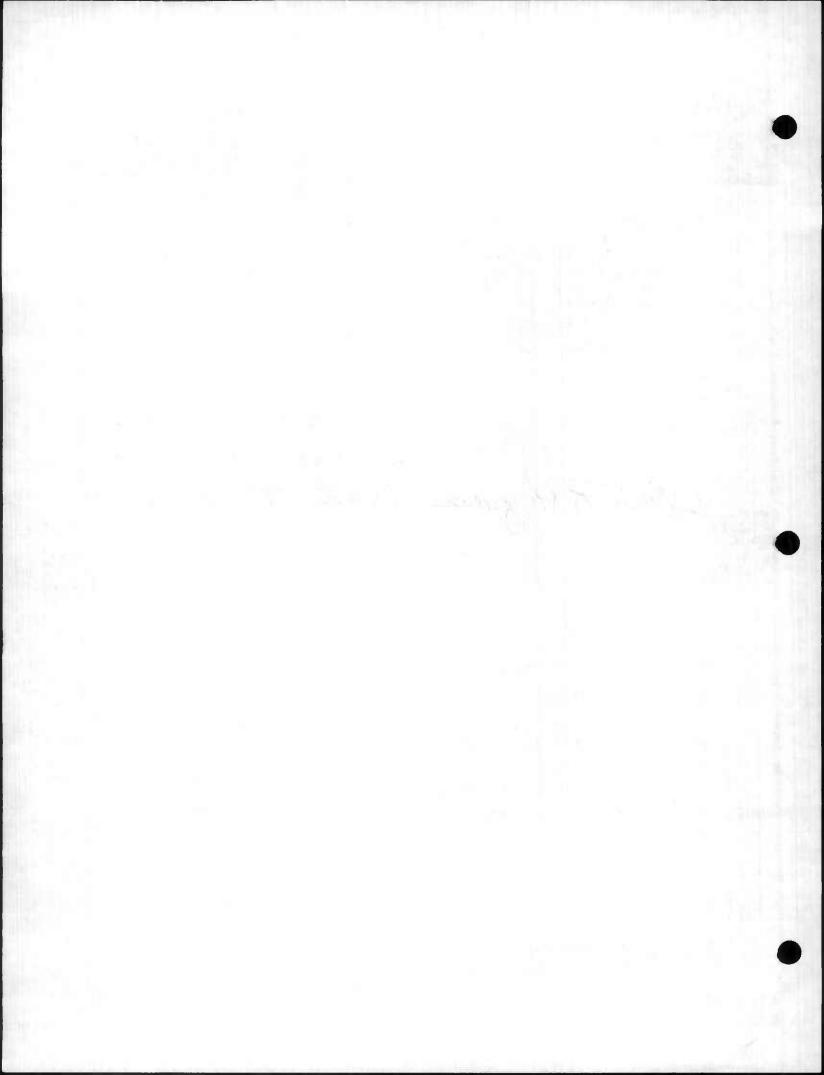
Items: 28acef Per MD Film G-758 4-2-98RC Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month 03 **Physician** 1634 km REDA R. CHANEY 25 /Medical 4a. Facility Nama (If not institution, giva straat and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY MONTGOMERY HOSPITAL OLNEY GENERAL If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 66 yrs. 8. Deta of Birth FEB 6,1932 6. Sax 9. Birthplaca (State or Foreign **Funeral** Days 1 M 200F Hours Min. VIRGINIA Director Usual Rasidance of Decedant the Manyland 10a, Stala 10b. County 10c. City, Town or Location 10d. Inaide City Limita 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at MD. MONTGOMERY ROCKVILLE 1X Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 529 BEALL AVENUE 20850 Funeral UNITED STATES 12. Was Decedant Evar In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yaa or No-If Yea, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarlcen Indian, Black, Whita, atc. 11. Maritai Status perxit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "necessary Injury or other terminal pages." 1 □ Navar Marriad 2 Married 1 ☐ Yes 2 Ø No If Yas, Give Yaar or Dates: 1 ☐ Yas 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) NURSING HOME NURSING ASSISTANT 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meldan Sumema) ANDREW PACE SARAH ELIZABETH 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) JOHN H. CHANEY, HUSBAND 529 BEALL AVENUE, ROCKVILLE, MD. 20850 20a. Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State GLEN HAVEN MEM. PARK 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 3/30/98 GLEN BURNIE, MD. 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funaral Sarvice Licensae 22. Name and Addrasa of Facility
MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Entar the disaesa, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intarvai Between Onset and Death Physician Immediata Causa (Final disaasa or condition resulting in death) /Medical CARDIO MYO PATHY Examiner Examiner INTRA DECRATIVE CARDIAC ARRHYTHMIA

Dua to (or as a consequence of): attending physician and for use es the burial-transit Sequentially list conditions, if any, leeding to Immadiata ceuse. Enter Undarlying Causa (Disease or Injury that initiated evants rasulting in death) Last Records, P.O. Box 68760, MEDIASTINAL TUMOR Physician/Medical Due to (or as a consequence of): KENAL FAILURE signed by the aid be dateched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Dayes 2 No 3 Probably 4 Unknown þ should I 24b. Were autopsy findings available prior to completion of causa of death? 24a. Waa an autopsy performed? Completed 2 000 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical B 26. Place of Death (Check only ona) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1) Inpatient 2 ER/Outpatient 3 DOA th: funeral 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Natural 5 Pending Invastigation death. To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yas 2 Accidant 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medical and mannar stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed ceuach daath (Itam 23a) (Type, Print) BARRY-50 W. EDMONSTON DR - ROCKULLE MDIOSSE MICHAEL 31. Data filed (Month, Day, Year) State 021998 Davidson-Randell Registrar



			State of Ma	aryıan				nealth and Death	Mental Hy	/giene Reg. No.	9.8	103	346
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es the bur	an/Medical Examine	Saquentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaesa or Injury that initiated avants rasulting in death) Last	с.	Oue to (o	r as a consaque	ance ot):						
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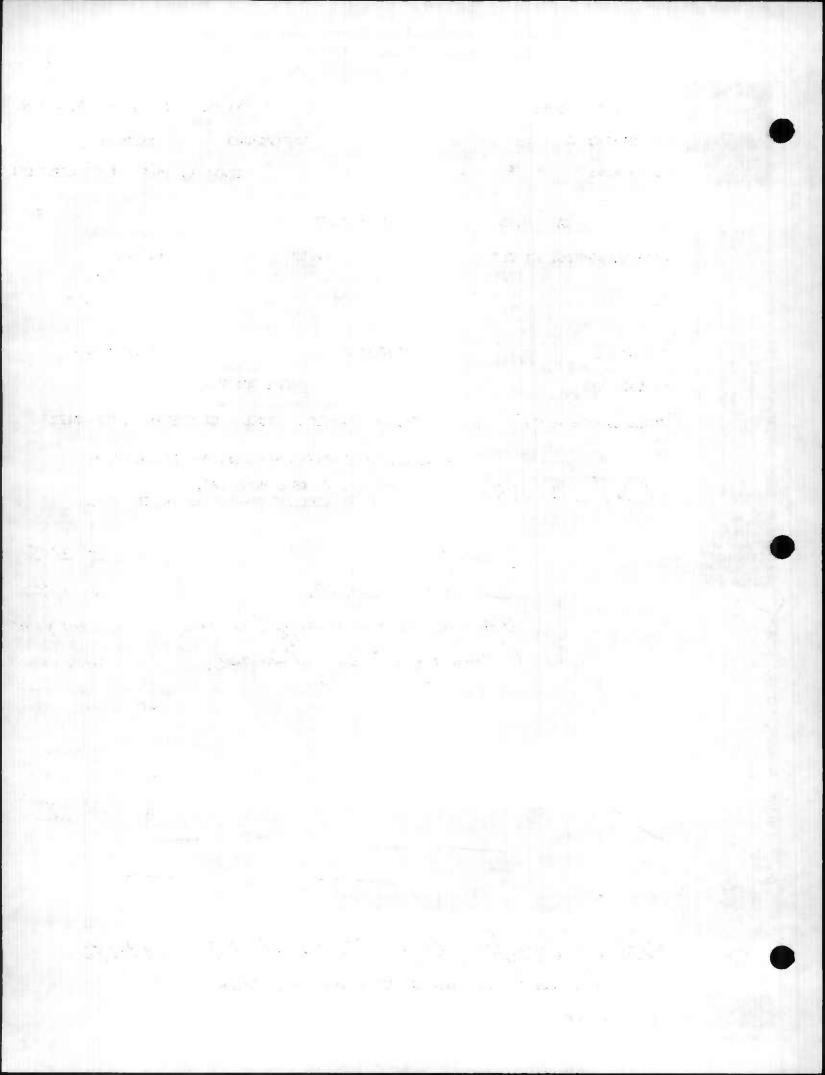
31. Data tiled (Month, Day, Year)

APR 0 2 1998

DR. BRAD J. COOPER - 52 WATER STREET - THURMONT, MARYLAND 32. Registrar's Signatura

21788

30. Nama and addrass of current who complated causa of death (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Me Certificate of Death			10348
	Bloomlai		Decedent's Neme (First, Middle, Last)	2. Dete of Deel	eg. No.	3. Tima of Death
Ų	Physici /Medio		ENTEN IBENE DIEGS N	MARCI	45, 1998	DNKWOWN
	Examin Funeral Director	er	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. F	DOY C. B. Dete of Birth (Month, Dey)	4c. County of Do N A Year) 9. E 3 190%]	Sirthpleca (State or Foreign Country)
	yland		Usuel Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location	•	J	10d. Inside City Limits
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	with th	Dire	106. Street end Number 107. Zip Coda	1	0g. Citizan of What	Country?
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Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Health and Mental hygiene. Item 27 is marked other than "natural", or items 23s or 23s-f show other traumetic event, the Medical Exemples must be notified at	by	1 Navar Married 2 Married 3 Wildowed 4 Divorced 1 Yes, Give Yeer or Deles:	can, etc.)	Specify:	4 44
215-(in 72 h n "natu	Completed	15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetlon (Giva kind of work done during most of working life. DO NOT use retired)	7	16b. Kind of Busines	ss/Industry
212	e filed within al Hygiene. other than "	Com	Elementery/Secondery (0-12) PHD. Educator	1	Morgan	State
and	ould be fill Mental Hi arked oth	Be	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (I	First, Middle, I	Maiden Súmame)	
anyl	2 should end Men ia marke aumatic	To	19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel R	Route Number	r, City or Town, Stete	a, Zip Code)
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altii	permit. Pag Department Important: i any Injury o		21. Signature of Funarel Service Licansee 22. Neme end Address of Facility		reray Ho)
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Вох	最 最 b	Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did to	phacco use contribu	ute to the cause of death?
P.O.	the och	Phys	ASTEVNIA	1 🗆 Y		Probably 4 Unknown
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Division	Attending or death. octor: After by the fune	catic	2 Accident investigation M 1 Yes 2 No	v. 1		
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end the basis of exemination end/or investigation, in my opinion, death occurred end menner stated.	d due to the ci l et the time, d	ause(s) and menner lete end pleca, end c	es steted. lue to tha cause(s)
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			MULAS L. LEDIN, 10 DOTO-000)	Vianch	10 1778
	0		30. Name and eddress of person who completed cause of death (Item 23s) (Type, Pfint) BAYMORE	= M	0 01	328
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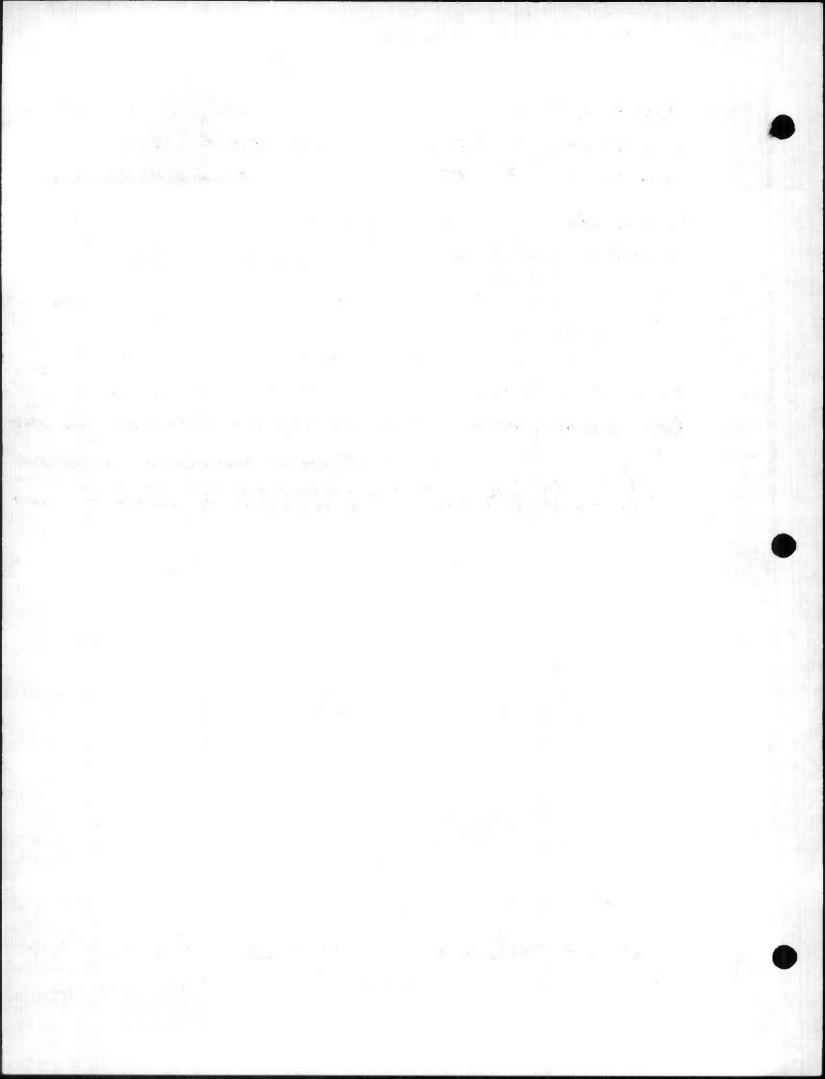
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State of Maryland / Depart

artment of Health and Mental Hygiene	98	103	L	5
rtificate of Dooth				

		Certificate of Death		Reg. No.	
		1. Decedent's Name (First, Middle, Last)	2. Date of D		3. Time of Death
Physici		LINDA DEVAUGHN	MARCL	1 3 7th 18	198 1:45 Am
/Medic	_		, or Location of Dea		
Examin	er		IMOKE		Death
				N/A	
Funeral Director		5. Sociel Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthdey) H Under 1 Yeer If Under 24 Months Days Houre 1	Min. (Month, D	orth ay, Year) 24-25, 1951 (V	Birthplece (State or Foreign Country) ARY(HNI)
D.		Usual Residence of Decedent			
ehow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Ma	5	MARYLAND N/A BALTIMORE			1 XYes 2 □ No
ith the M or 28a-f	9	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	it Country?
23a c	2	2509 ROCKROSE AVENUE 212	11	().S.A.	
Jeatl me 2	er	11. Maritel Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or N	/ \ .	American Indian,
re, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. tem 27 is marked other than "naturel", or Neme 23s or 28s-f ehow other treumatic event, the Medical Example mentals notified at	by Funeral Director	Armed Forces? 1 Never Merried 2 Married 1 Yes, 2 No 1 Yes, Give 1 Yes, Give 1 Yes 2 No 1 Yes, Give 1 Yes 2 No 1 Yes 2	uerto Rican, etc.)	Specify:	White, etc. BLACK
2 ho	Be Completed	15. Decedent's Education 16a. Decedent's Usuel Occupation		16b. Kind of Busin	nass/Industry
Pin 7	9	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	working		
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aryic should nd Men marke umarke	2	19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
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Ce, Maryland 212. 1 and 2 should be filed within Heelih and Mental Hyglene. To a marked other than ther treumatic event, the	ŀ	30.11000			
Saltimore, IV permit. Pages 1 and Department of Health Important: If them 27 any Injury or other tr ones.		cemetery, cremetory or other place)	Date	20c. Location - Cit	
Pag nent ant: h		4 Donetion 5 Other (Specify) 4 Donetion 5 Other (Specify)	14-4-98	LANSDOW	NE, MARYLAND
Baltimore, permit. Pages 1 ar Department of Hea Important: If Nem ; any Injury or other	Ì	as all the state of the state o			
m asesa		21. Signatura of Funeral Service Lauriage 22. Name and Address of Facility JOSEPH H. BROW	WIRFU	VERM M	MARYIANA DIDIT
	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car			
	6 1	shock, or heart failure. List only one ceuse on each line.	rollac of respiratory	irrest,	Approximate Interval Between Onset and Death
Physician					Criset and Death
/Medical Examiner	.	Immediate Cause (Final disease or condition Lespiratery Failure			
Cxamine		resulting in death)			
	Je l	CFREBRAL VON CULO	acadas		
1 2	Examiner	0.			
1 / 1		if any, leading to immediate			
5/8 (3 B	edical	cause. Enter Underlying Cause (Disease or Injury that Initiated events			
0 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	ğ	resulting In death) Last			
(15 g g	3	d seighes			
attend for us	lan	U			
the g	Sic	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dio	tobacco use contri	bute to the cause of death?
The law requires that the death can be law requires that the above signed by the attence of a should be datached for us	Physician	Pulnevary Embolus	10	Yes 2□ No 3	□ Probably 4 ☑ Unknown
and de de	by	- CONTRACTOR COMITO (US	_		
w requires that been signed I should be dat			24a. Wa	s an autopsy 2	24b. Wera autopsy findings available prior to
w requ	Completed			omeor	completion of cause of death?
Physicien: The law requires the certificate has been signed rial director, page 2 should be considered.	Ē				
cate			1L	Yes 2 No	1 □ Yes 2 □ No
certificate	Be	exeminer?	Death (Check only	one)	
Physicien: rhis certific	2	1 Yes 3 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursi	ng Home 5 ☐ Res	idence 6 Other	(Specify)
de Ph	Ë	27. Manner of Death 1 ☑ Alaturai 5 ☐ Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work?	28d. Describe	how Injury occurred	
or Attending after death. Director: After	atic	1			
Attending ir death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 26e. Piece of Injury - At home, farm, street, factory, office	28f. Location	(Street and Number	or Rural Route Number,
Diragi	ert	4 ☐ Homicide building, etc. (Specify)	City or 10	iwn, State)	
To the Hospital or Attending F within 24 hours after death of the Funeral Director: After complately filled in by the funer	2	29a. Cartifier US Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	ince and due to the	causa(s) and man-	er as stated
Fun fiely	edical	(Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death of	occurred at the time	, date end place, and	due to the cause(s)
To the within 2 To the compla	Mec	. Granitation godes.		20d Data signed #	Month Day Voer
5 × 5 × 5	-	29b. Signature end title of certifier 29c. License number		29d. Dete signed (f	
r r		Monce J. Oranly M.D 13720	13	MYTICH	30th 1998
		30. Name and address of person who completed cause of death (item 23a) (Type, Print)	0 1	(
1		Teravce Um3 mis diberty medical center	9 Balt	enae ind	Alais
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registr.		ADD 02 1998 July Neighbor-Randell			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DA DAY-BOLDEN 2:27 AM MARCH 1928 26 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner HOSPITAL CENTER HARbor BALTIMORE N 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 212-12-988 1 M 2 F Days Yrs. Director VIRGINIA Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examinar must be notified at 1 Yes 2 No Directo MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 252 WALBROOK AVE 706 USA. Funeral 14. Rece - American indian, Biack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Hem 27 is merked other than "natural", or fren any injury or other traumatic event 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

...
... 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ZYRS CLERK WOMEN'S CLOTHING STORE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ELLIS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 335 ED WAY CIRCLE RANDALLSTOWN MD 21133 of Diagonition (Name of Date 20c Location - City or Town, State DOROTHEA DAY-WHITE (NEICE) 20b. Place of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS CEMETERY 4-01-98 BALTIHORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE, HD. 21217 23e. Pert1. Enter the disease, or complications that caused the beth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical INFANCTION MYOCARDIAL **Examiner** Physician/Medical Examiner CARDIOVASCULAR DISEASE Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEGENERATIVE Completed by 24b. Were eutopsy findings avelleble prior to completion of cause ol deeth? 24a. Was en eutopsy performed? RhabbonyoLysis 1 ☐ Yes No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to Be 25. Was case relerred to medical examiner? 28. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide The prifying Physician: To the best of my knowledge, deeth occurred at the time, date and piaca, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

3001 South HANDUER STREET

29d. Date signed (Month, Day, Year) MARCH 26, 1998

BALTIMONE

MARYGUD

State Registrar

29b. Signature end title of certifier

31. Date filed (Month, Day, Year)

APR 02 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

DASARO

32. Registrar's Signature

When Davidson

PETER

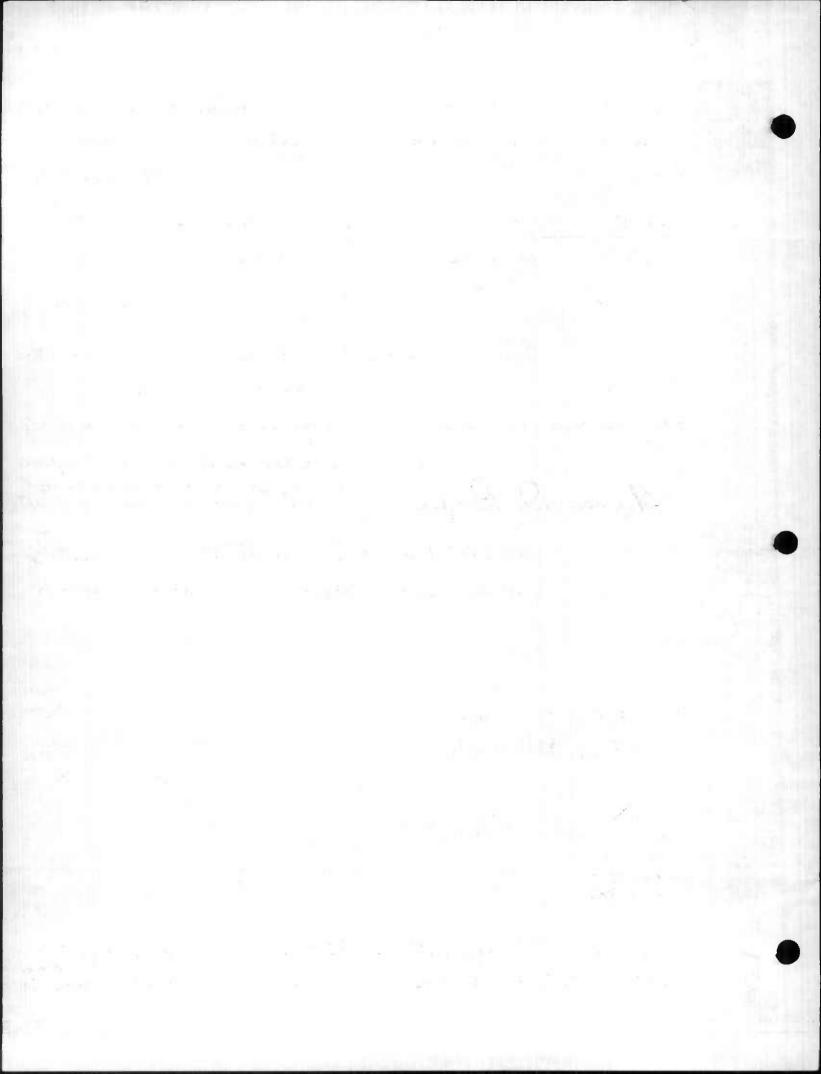
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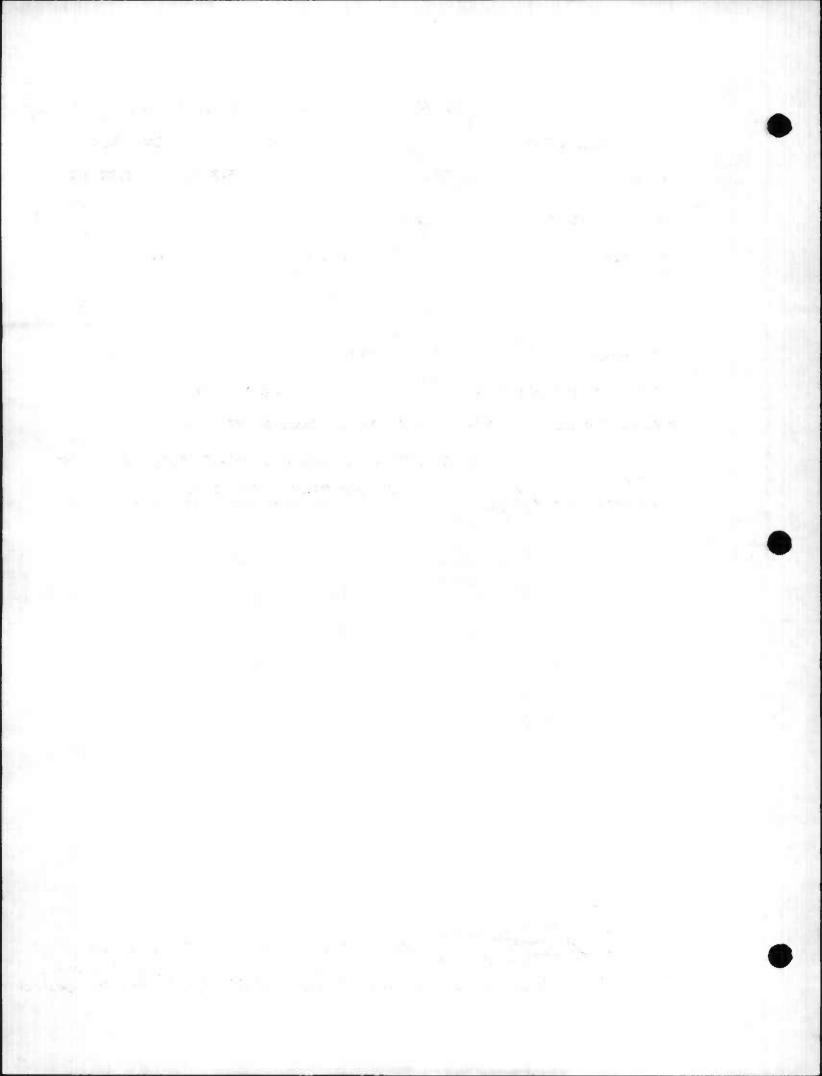
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State of Maryland / Department of Health and Mental Hygiene

Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exterine must be notified at one any injury or other traumatic event, if a Medical Exterine must be notified at one any injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be notified at one and injury or other traumatic event, if a Medical Exterine must be not one and injury or other must be not one and injury or	4a. Facility Ne ST. 5. Social Secu 218-07 Usual Resider 10a. Stete MD 10e. Street an P.O. 11. Marital Ste 1 Nevar 3 Widov 17. Fether's No GFOF 19e. Informen MARGAF 20e. Method o 1 10 Burie 4 Done	JOSEPH HOS rity Number 6.7–3577 ce of Decedent 10b. County CALVER d Number BOX 391 tus Married 2 Married ed 4 Divorced 15. Decedent's Is Specify only highast g Secondary (0-12) GRADE ome (First, Middle, Las GE SEBASTI 's Name/Reietionship	POSTAH inve street and number) SPITAL Sax 1 XM 2 F 7. Aq 12. Was Decedent Armed Forces 1	ge (In yrs. last i 80 10c. City, To SOLOI Ever In U.S. No	Wn or Location MONS 13. Was If Yas 1	Under 1 Yaar onths Deys Of. Zip Coda 2068 Decedent of Its, specify Cub Yes 2 3 No Is Usuel Occup to f work done NOT use retire	Hours Min. 88 Hispanic Origin? (Seen, Mexican, Puerling)	B. Dete of Bir (Month, De 3/31/)	th Ac. County BALT The Ac. Co	yeer y of Death PIMORE 9. Birthplace (Secontry) MARYLAN 10d. Ins 10 What Country? 2e - American Indick, White, etc. WHITE usinass/industry	D side City Limits] Yas 2⊠No
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To the Funeral Director: A completely tilled in by the tr	29e, Certifier (Check onlone)	1∐ Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of end mannar ste	exemination a	je, deeth occ nd/or investig	curred et the ti getion, in my d	me, dete end plece opinion, deeth occu	, end due to the rred et the time,	ceuse(s) end ma dete end piece, a	anner as stated. and due to the ce	ouse(s)
To the complet		and title of certifler			6	29c. Licens	se number		29d. Data signe	d (Month, Day, Y	ear)
	16	Leites	HADO L	, well	ma	500	09383	2	Marc	130,1	1998
	30. Name and	address of person who	completed cause of d	leeth (item 23e	(Type, Print	1111	Jan 1.7	dill	0180	Him u	re 1710.
State	1/1	Month, Dey, Year)	32. Registr	ar's Signature		11117	-11/2-1	TILL	10 1	101 // Jynd	MX/6



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** HELEN DOLL MARCH 28, 1998 9:06 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 22, 1928 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min 69 Yrs. 212-28-9296 Virginia Director Usual Residence of Decedent death with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2 No Baltimore Parkton Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 18604 York Road 21120 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or hen any injury or other traumatic event, the section of the 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automotive Parts Elementary/Secondery (0-12) College (1-4or 5+) Manufacture Machine Operator 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Charley J. Collins Anna M. Lipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bisker W. Doll/Husband 18604 York Rd., Parkton, MD 21120 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 1, Burial 2 □ Cremation 3 □ Removal from State Stablers Cemetery 1998 4 ☐ Donation 5 ☐ Other (Specify) Parkton, MD 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease shock, or heart failure. U caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical ADULT RESPIRATORY DISTRESS SYNDROME Examiner Due to (or as a consequenca of) Physician/Medical Examiner PNEUMONIA requires that the deeth certificeta be axecuted attending physician end for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequença of) Box 68760 thet initiated events resulting in death) Last Due to (or as a consequenca of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown yd bengis need Records, þ 8 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed The lew certificate has 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 70 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury et Work? 27. Manner of Death 28b. Time of Certification: or Attending Naturel 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piaca, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and piece, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of cartifier 03-28-98 nohoro D30263 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) FRANCIS KHOO M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 31. Date filed (Month; Dey, Year) 32. B strar's Signeture State La Davidson Randall

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Registra

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 27, 1998 Ahraham Deutch 6:30 pm march Aven ne 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number) 4c. County of Death Sinai Ito Spital 2401 5. Social Security Number 6. Sex West Belvedere Ba(+imore II Under 24 Hrs. 8. Date of F N/A 7. Age (In yrs. last birthday) If Under 1 Months Birthplece (State or Foreign Country) 1**X** M 2□ F Hours 218-32-1104 LATVIA Usuat Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 W. BELVEDERE AVE, APT. 512 USA 21215 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specity: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 OWNER RCOFING & SHEET METAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) CHATZKEL DEUTCH DUSHA FIVERSOHN MRS. ALICE DEUTCH (WIFE) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 W. BELVEDERE AVE, AP¢T. 512 BALTIMORE, MD 21215 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State BETH TFILOH 3-29-1998 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 8900 REISTERSTOWN RD BALTIMORE, MD 21208 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List gary one cause on each line. Approximate intervel Between Onset and Death Immediate Cause (Final Congustive Heart Failure Due to (or as a consequence of): disease or condition resulting in deeth) Coronary artery disease Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last c. my ocardial infarction Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medicai

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be nothed at

"natural",

Hygiane.

permit. Peges 1 and 2 should be filed wit Department of Health and Mental Hygiana important: If frem 27 is marked other tha any filury or other traumatic event, Ital 000cs.

Baltimore, Maryland 21215-0020

Director

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Completed

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Box 68760

Physician/Medical þ Completed Be Certification: To After thi

P.O. Records, Division of Vital I or Attending Physician: after death. **Director**: To the Hospital or within 24 hours aft To the Funeral Di complately filled in

Medical

Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. memia 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 1 Netural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one)

30. Name and address of parson who completed cause of death (Item 23e) (Type, Print)

29c. License number luterni-AS 2402321-Internal.

29d. Date signed (Month, Day, Year)

Top medicine

March 27, 1998

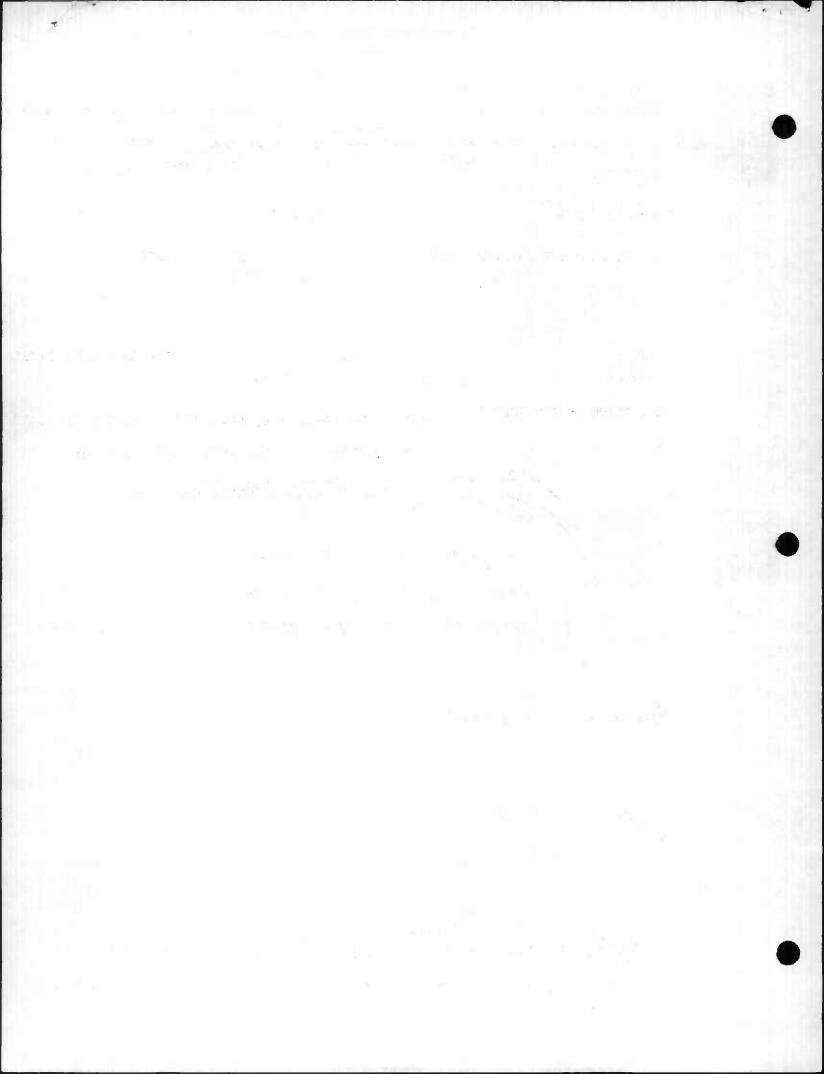
Amaham, mp Sinai Hospital, 2401 west Beliedere Avenue Anna

Baltimere mb 2/215

31. Date filed (Month,

29b. Signeture and title of certifier

182 Registrar's Signature July Davidson Randall



State of Man	yland / Departmen		Mental Hygie		42-	0354
. Decedent's Name (First, Middle, Last) Levander	David		2. Date of Deeth Month March	Day 28,	Year 98	3. Time of Death 3:50pm
a Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	4c. Count	y of Death	

Funeral Director

Physician /Medical Examiner

with the Maryland ahow r 28a-f show Director "netural", or items 23a or death Funeral à Completed

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a filed within 72 hours after if Hygiene. other than "netural", or ite permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If flem 27 is marked othe any Injury or other traumatic event DAGS. Physician

altimore, Maryland 21215-0020

/Medical Examiner

Physician/Medical Examine Division of Vital Records, P.O. Box 68760 The law requires that the death certifical the the signed by t been significant page 2 s has certificate To the Hospital or Attending Physician: director 10 After this funeral death. Director: / after

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Certification:

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within 24 hours a completely State

Church Home Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Months Days Hours XXM 20F 237-44-6621 62 Yrs 09-23-35 NC Usual Residenca of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Md. NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5218 Saybrook Road USA 21206 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade NA Welder General Motor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) David Wyetter Goodwin Alexander 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5218 Saybrook Road Baltimore, Maryland 21206 Carolyn David 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 04-03-98 Cem. Arbutus Mem. Pk. Arbutus, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue V 23a. Part1. Enter the disease, or complications that caused the death, Do not amble the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury

resulting In death) Last

Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death? 1 Nes 2□ No

Yes 2□ No

28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Dey Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

Hospitel:

5 Pending Investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 100 N BROADWAY GEORGE OMAS

31. Date filed (Month, Dey, Year)

25. Was case referred to medical

1 Yes 2 No

27. Manne of Death 1 Natural

2 Accident

3 Sulcide

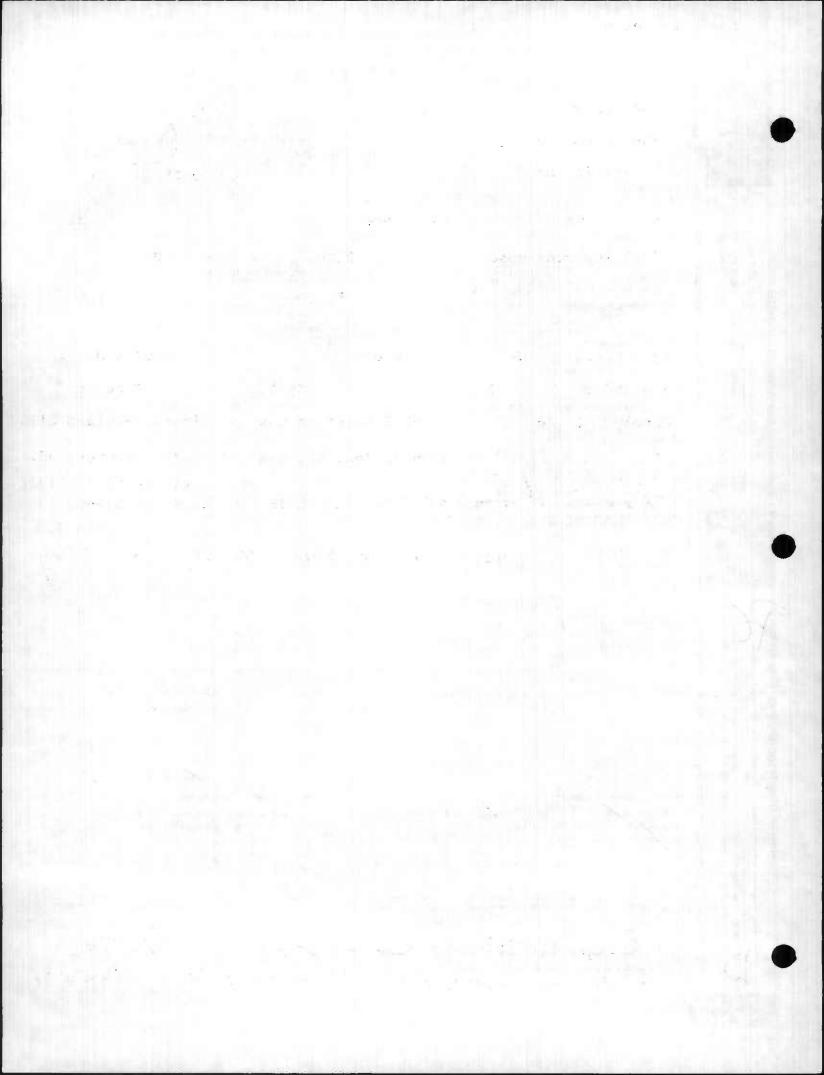
29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signeture 02 APR

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decadent's Nama (First Middle Last) 2. Data of Daath Month JOHN DOMINIC DAVIS 1:00 am 98 March 30 4a. Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Catour ville Charlestown Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. 02/28/1918 5. Social Sacurity Number Birthplace (State or Foreign Country) MARYLAND 6. Sax 1 → M 2 □ F 7. Aga (In yrs. last birthday) 80 Yrs. 214-18-0317 Usual Rasidence of Decedant 10b County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 719 MAIDEN CHOICE LANE HR 209 21228 U.S.A. 12. Was Decedant Evar in U,S. Armad Forces? 1 (☆ Yes 2 □ No If Yas, Giva Yeer or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puarto Ricen, etc.) Rece - American Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 X Married 1 ☐ Yas ZENo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorcad 16a. Dacedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/induatry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) PROPERTY ASSESSOR STATE OF MARYLAND 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) WILLIAM PATRICK DAVIS, SR. MARY BUCKLEY 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RITA M. DAVIS/WIFE 719 MAIDEN CHOICE LANE HR 209 CATONSVILLE, MD 21228 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Ramoval from Stata GARRISON FOREST VET. CEM. 4/3/98 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) o of Fugera Septis Licensee 22. Nama and Address of Fecility 21. Signatu STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 Inter the disaasa, or complications that ceusad tha deeth. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, refer that the mode of dying, such as cerdiac or respiratory arrast, refer that the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, such as cerdiac or respiratory arrast, and the mode of dying, and the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the discovered by the mode of dying are discovered by the dying a Approximeta intarval Betw Onsat end Death Immediate Causa (Final Months Ung disaase or condition rasulting in deeth) Cancer Due to (or es e consequence of) Dua to (or as a consequence of): Dua to (or as a consequance of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructive Pulmongny Disease

Physician /Medicai **Examiner**

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

6

items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

traumatic event, the Medical Examiner must be notified at

the Maryland

Box 68760, The law requires that the death certificate P.O. been signed by should be detac Records, certificate has of Vital or Attanding Physician: Director: After this

Physician/Medical þ Be Completed Certification: To illed in by the funeral To the Hospital within 24 hours a To the Funeral Completely filled

Sequentially list conditions, if any, laading to Immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. Wera autopsy findings available prior to complation of ceuse of daath? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 20 No Dementig 25. Wes cesa referred to medical axaminer? 28. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Deta of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Dascribe how Injury occurred 1 Neturel 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicida Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as attated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner steted. 29e. Certifian 29b. Signetura and titla of certifiar 29c. Licensa number 29d. Date signed (Month, Day, Year)

D 51051

March 30

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Hospital

Division

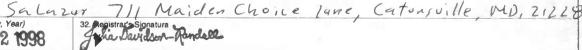
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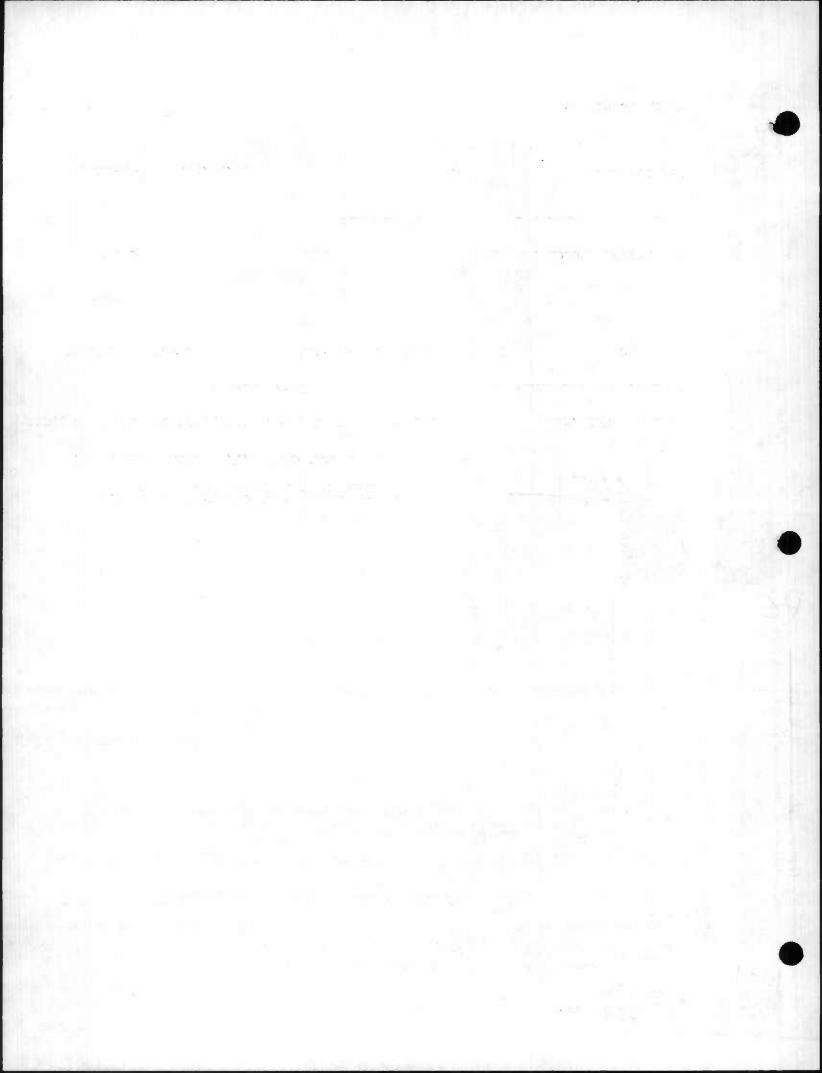
State Registrar

31. Data filad (Month, Day, Year) APR 0 2 1998

andres

30. Neme and address of person who complated ceuse of death (Itam 23e) (Type, Print)





State of Maryland / Department of Health and Mental Hygiene Item: 17 Per FH Film G-758 4-2-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Daath 3. Time of Death **Physician** 1255 am Sadie Estrin march /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Sinai Itospital of Baltimore, 2401 W. Belvedere AVE 7. Age (In yrs. last birthday)

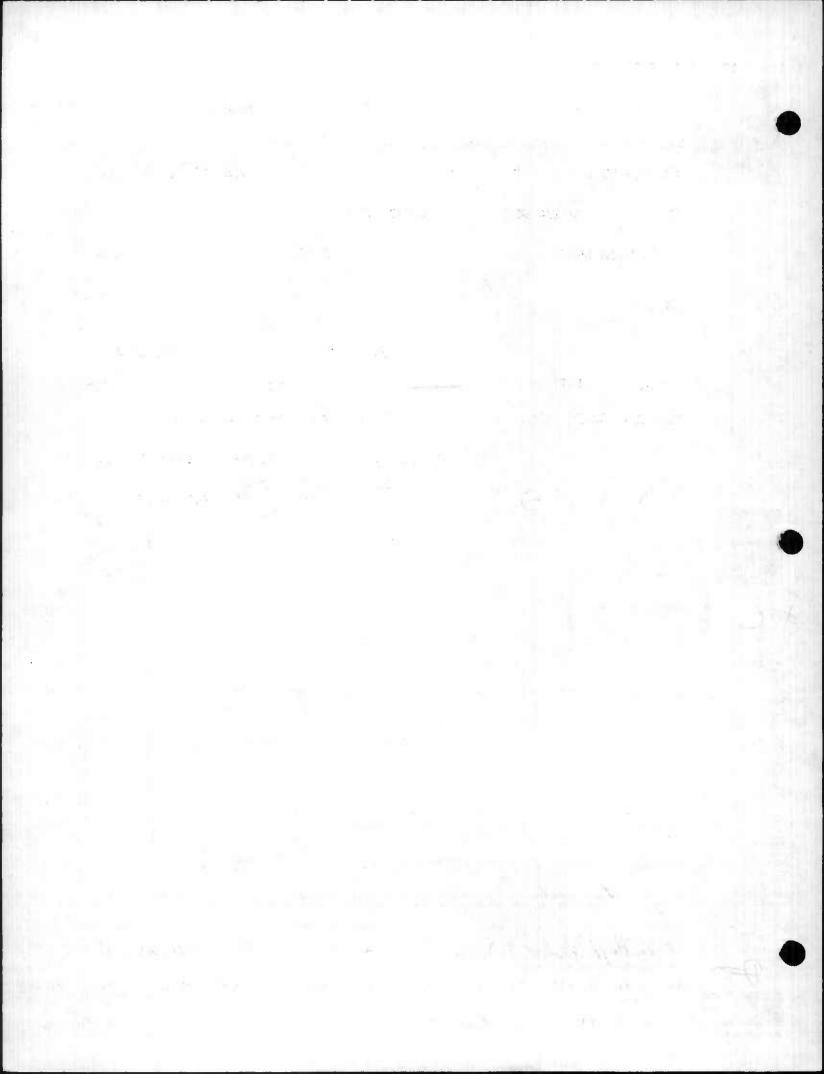
Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | JUNE 21, 1906 Baltimore 5. Social Security Number 6. Sex 9. Birthpiece (State or Foreign **Funeral** 1□ M 2□ F RUSSIA 132-09-3891D Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or frems 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD BALTIMORE OWINGS MILLS 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 39 RITTERS LANE 21117 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or frems 23a any Injury or other traumatic average. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11. Meritel Status 14. Rece - Amarican Indien. 1 ☐ Yes 2 No If Yes, Give 1 Navar Married 2 Married 21215-0020 WHITE 1 Yes 2 No Specify: by Specify 3 ₩ Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME Maryland 17. Father's Nema (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Be LISTIZKY LISTYKY **GEDALIA** ZISHA LINKNOWN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CHARLES ESTRIN (SON) 39 RITTERS LANE OWINGS MILLS, MD 21117 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 Removal from State 3/29/98 4 Donetion 5 Dother (Specify) BETH MOSES PINELAWN, LI, NY 21. Signature of Funeral Service Licensi 22. Name end Address (Earling BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, 8900 REISTERSTOWN RD., PIK.

In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, that fellure. List only one cause on each line. MD 21208 Approximete intervel Between Onsat and Death **Physician** /Medical Immedieta Ceuse (Finei Congestive heart failure 6 days disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ettending physic for use as the Dua to (or as e consequence of) or Attending Physician: The law requires that the deeth certificate Urosepsis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown Parkinson's disease Division of Vital Records. þ Be Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Senile dementia Hypertension After this certificate 2 No 1 □ Yes 2 □ No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending Investigation 1 Meturel death. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) end menner steted. 29a. Certifier Medical (Check only 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signed (Month, Dey, Year) PhD, DO AS2402321-59-9169 03,26,98 who completed ceuse of deeth (Item 23a) (Type, Print) 30. Neme end eddress of person Shelley A. Quarless PhD, Do, Dept. of Medicine, Sinai Hospital of Baltimore, Baltimore MD 21215
31. Date filed (Month, Day, Year) | 32. Registrer's Signature 31. Dete filed (Month, Dey, Yeer) State Registrar Like Twiden Hondell



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Please T	Type or Prin						_	_	ble.	257
		(Certifi	cate o	f Death		Reg	J. No.	, 10.	337
Decedant's Name (First, Middle, Last) John Francis Ebber							2. Date of Death Month arch	Day 31	Yeer	Time of Death: 05 p.m.
Facility Neme (If not Institution, give s	street and number)				4b. City, Tov		ation of Deeth	4c. County		, , , , , , , , , , , , , , , , , , ,
217-54-3159		e (In yrs. lest birth 47 Yr		Under 1 Yea onths Day		4 Hrs. 8	8. Date of Birth (Month, Dey, Y ept. 24,		9. Birthplece (Country)	(State or Foreign
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800 Grand Bend Dr			:	21228			τ	Inited	States	
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15. Decedant's Educ (Specify only highest grade Elamantary/Secondary (0-12) 12		5+)	(Give kind o life. DO N	VOT use reti	ne during most	of working	9		ng Compa	
. Father's Name (First, Middle, Last)							(First, Middle, Me	iden Sumem	(e)	
arry Ebberts					Rose					
e.informant's Name/Relationshlp (Tyr. Trank Ebberts / Bro							Route Number, (-
e. Method of Disposition 1 Buriai 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	20b. Place of E cemetery, Loudon	, cremetor	ry or other p	olece)	4/			City or Town, S	tete
Signature of Funeral Service License	free		22. Nar	me and Add	dress of Facility		don Park , Baltim			
3a. Pert1. Enter the disease, or complic shock, or heert failure. List only on mediete Cause (Final saase or condition	na cause on each lin	ne.				ardiac or	raspiratory arres	1,	tnter	roxtmata rval Between et end Death
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equentielly list conditions, any, leading to immediate use. Enter Underlying suse (Disease or Injury et initieted events sulting in deeth) Lest		Due to (or es e co	onsaquenc	ce of):						
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rt II. Other significant conditions conf	tributing to death bu	ut not rasulting in t	tha undarly	ying ceuse	given in Part I.		23b. Did tob	acco uaa coi	ntribute to the	
			<u>.</u>				24a. Was an performe		availabte	utopsy findings e prior to tion of cause 17
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a Cartifiar Cartifidae Dhuai	To the book	4 . 1 - 1 . 4 -	de este e e		. 4:	1 1	and alice to the con-	(-)d		

Physician/Medical Examiner þ Completed

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Certification: To

Medical

ettending physician end for use es the burial-transit ed by the e s been signed by the should be detach s certificate has b director, Director: After this d in by the funeral di

or Attending Physician: The law requires that the deeth certificate be executed

efter deeth.

filled in by

Division of Vital Records, P.O. Box 68760,

25. Was casa referred to medicine exeminer?

1 Yes 24 No

27. Manner of Death

1 Naturel 5 Pendinvest

1. Decedant's Name (First, Mid

4e Facility Neme (If not Instituti

217-54-3159 Usuai Residence of Decedent

Maryland | Balti

12 17. Father's Name (First, Middle

Harry Ebberts 19e. informant's Name/Relation Frank Ebberts 20e. Method of Disposition 1 Buriai 2 ☐ Cremation

21. Signature of Funeral Service

23a. Pert1. Enter the diseese, shock, or heert failure. Lis

immediete Cause (Final disaase or condition rasulting in daath)

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

Part II. Other significant condit

10e. Street and Number 4800 Grand Ben

11. Maritel Stetus

10a. State

Directo

Funeral

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Completed

Be

4800 Grand Be 5. Social Security Number

Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Pryglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Experience must be notified at 000.0.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

29a. Cartifiar (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and macro on the basis of examination end/or invastigation, in my optnion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

29b. Signature and) completed cause of death (item 23a) (Type, Print)

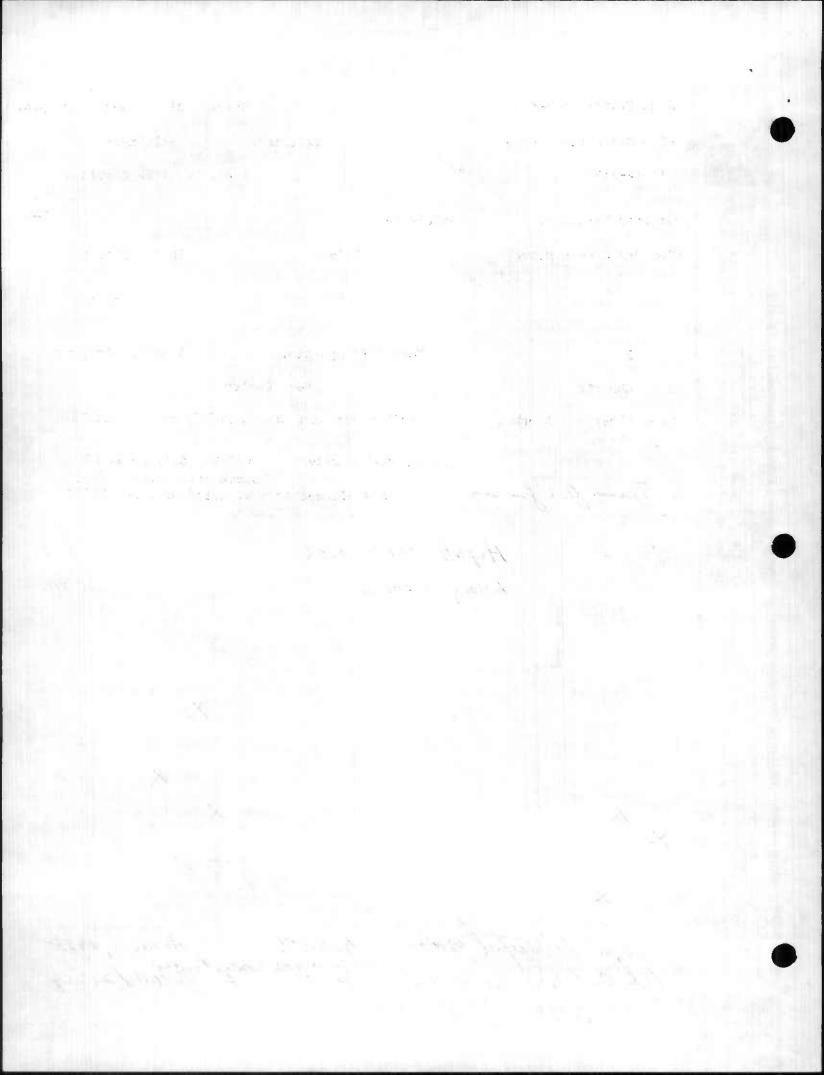
29d. Date signed (Month, Dey, Year)

State Registrar

31. Dete filad (Month, Day, Year)
APR 0 2 1

MIENFIELD 32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Daath 3. Time of Death Month **Physician** -en9 2:22 AU Edenta March 1998 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimorc Geriations Center HOPKINS If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign 5. Social Security Number **Funerai** 1□M 200 F Days 75 218-22-6409 Yrs. Kentucky Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important if them 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Medical Exertines must be notified at BAltIMORE 1 Yes 2 No Director MARY/AND 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 270 HIGHLAND South HUENUC U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Navar Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Eiamantary/Secondary (0-12) Collage (1-4or 5+) Meat INdustry ASSEMBLER 12 18. Mother's Name (First, Middla, Maidan Sumame) 17. Father's Name (First, Middle, Last) Be BRASCUE GREENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) UR BAHOMd 21224 MANCY -(AN) EIMER South 270 COMPANION 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY 3-31-98 BAltIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) DAKLAWN 21. Signature of Prograf Service Licensee 22. Nama and Address of Facility
Charlton Funckal Home CHARLTON anners EASTERN AVENUE BATTO. Md 21231 2005-07 indications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, one cause on each line. 23a. Parts. Enter the disease, or or shock, or heart failure. Slat or Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai . Chronic Obstructive Rumonary Disease Examiner Due to (or as a consaquance of): Hypercophia Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated events rasulting In death) Last Due to (or as a consequence of): Box 68760, ein Physician/Medical 2 attending 990 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 8 1 Yes 2 No 3 Probably 4 Unknown Hyperthyrold, preumonia 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy parformad? 2 No 1 ☐ Yes 2M No 25. Was casa referred to medicat examinar? 26. Placa of Daath (Check only ona) Hospitat: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: Athar 1 Naturai 5 Pending Investigation if or Attending after death. Director: Att 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours of Funeral C 29a. Cartifiar Certifying Physician: To the bast of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature, and tiNe of certiling. 29c. Licanse number

State Registrar 31. Date filed (Month, Day, Yaar)
APR 0 2 1998

30. Name and address of person who some

32 Registrar's Signature

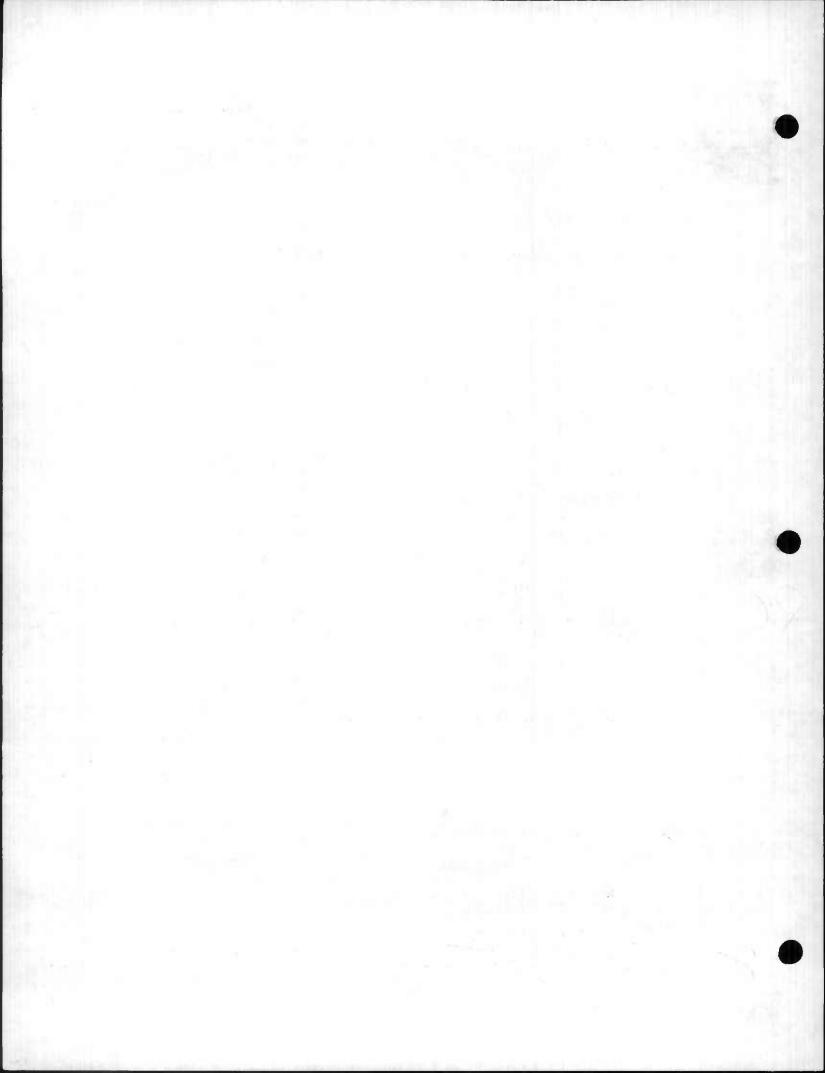
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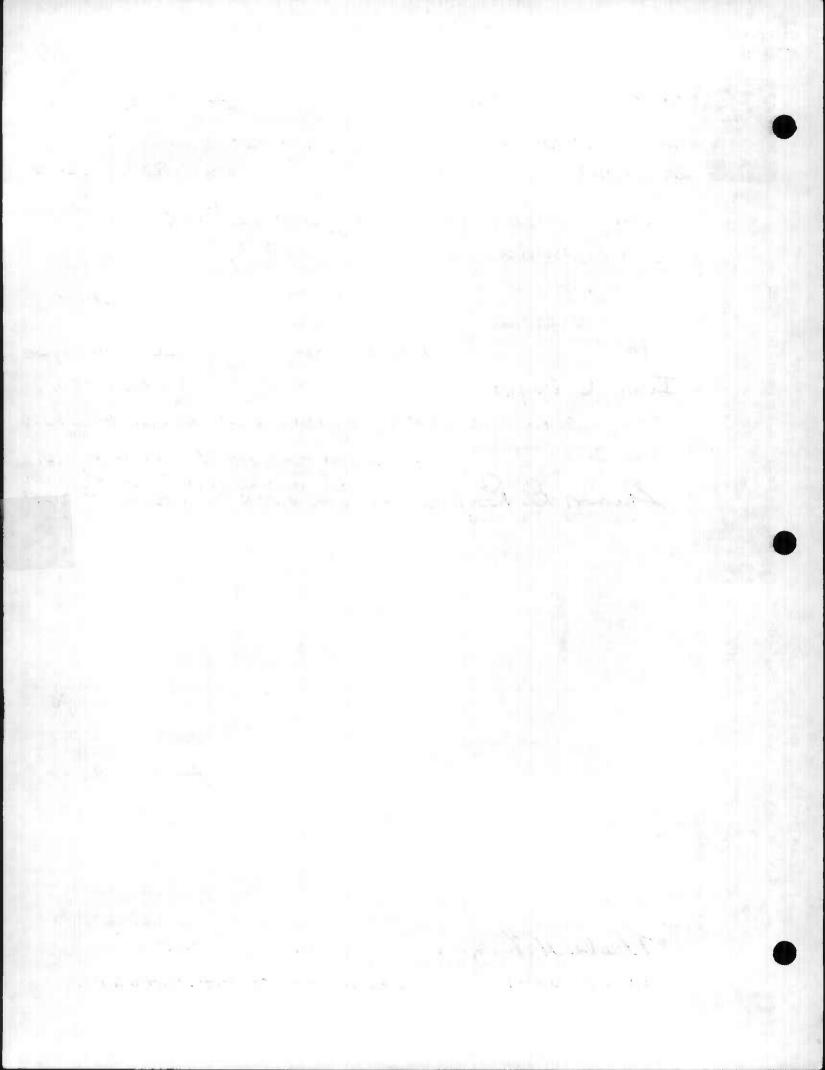
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State of Maryland / Department of Health and Mental Hygiene 98

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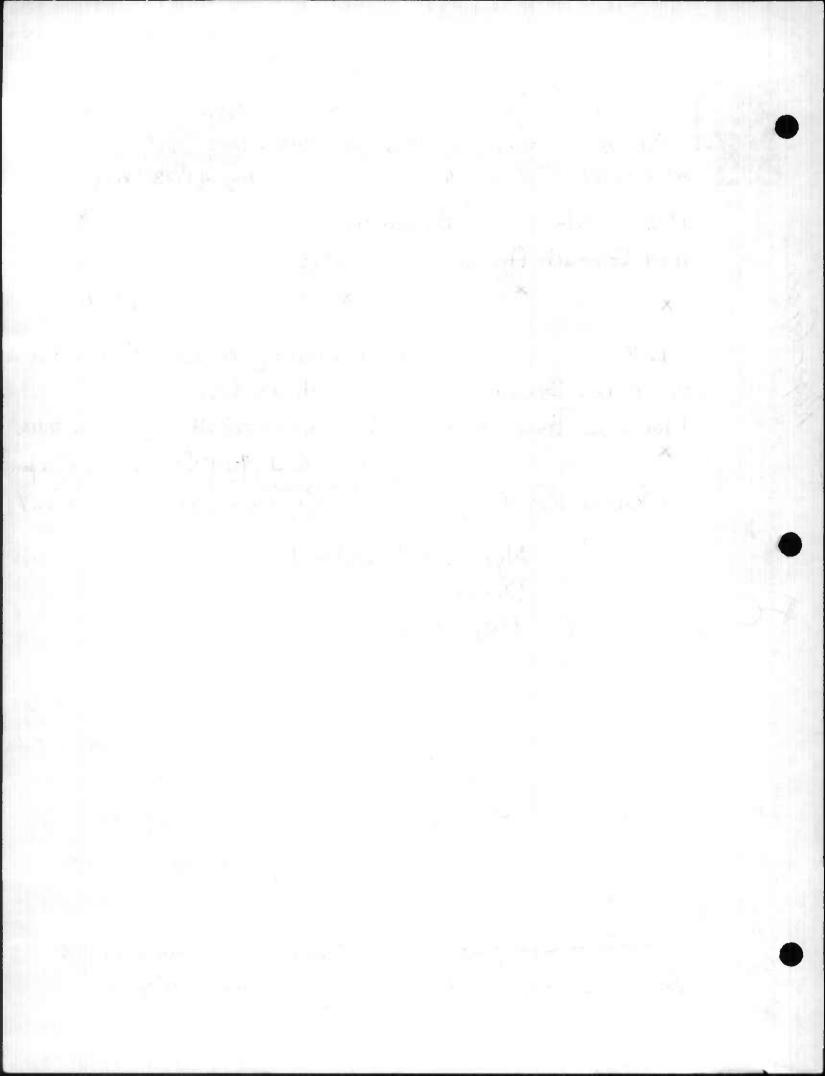
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2 = 2	20a. Mathod of Disposition 1 Burial 2 Cremation 3		10		ocation - City or To	
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State	ADD 02 199	32. Ragistyar's Signature	0 .			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day 7, 1998 4c. County of Death **Physician** GREEN OGER /Medicai 4b. City, Town, or Location of Death **Examiner** 9405 If Under 24 Hrs Hours Min. If Under 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 102M 2□F Months Days 217-24-2989 Usual Residence of Decedent Aug. 21, 1928 Director ricaruran 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits traumatic event, the Madical Examiner nust be notitied at Baltimore 1 Yes 2 □ No Director 28a-f Id. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 238 USA Funeral Hvenue 21218 Hems 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status pernit. Peges 1 end 2 should be filed within 72 hours after Depertment of Health end Mental Hygiene. Important: If fem 27 is marked other than "natural", or then any injury or other traumatic event. The Menter Experience 1 MYes 2 No KOREAN If Yes, Give Year or Dates: WAR 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced WAR Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Roger da 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) De Place of Disposition (Name of cemetery, crematory or other place) 1124 Gorsuch Avenue Battimore Maryland 21218
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Joseph H. Brown 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that ceused in death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart feilure. List only one cause on each line. N. Fulton Avenue, Baltimore, Maryland 21217 Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner abetes Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, pertension Due to (or as a consequence of): 98 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 1 Yes 1 ☐ Yes 2 ☐ No Mospital or Attending Physician:
 24 hours effer death.
 Funeral Director: After this certificaletely filled in by the funerel director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yeş 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier edical 1 dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 40 MARYLAND GENERAL HOSpital Kolongo 3e. Agistrar's Signature July Davidson-Randale 31. Date filed (Month, Day, Year) State APR 02 1998 Registrar



98-1768-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene CLEOTHIN Item: #8 Per FH Film G-758 4-2-98RC GARRETT Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2 Date of Death Dey **Physician** 29, 1998 4c. County of Deeth MARCH 21:29 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Nema (If not institution, give street and number) Examiner UNIVERSITY HOSPITAL BALTIMORE If Under 24 Hrs. If Undar 1 Year Date of Birth (Month, Dey, 5. Sociel Sacurity Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Country) **Funeral** 12M 2DF Months Days Hours Min 22 226-84-9064 Usuel Residence of Decedent Yrs. MD Director with the Maryland r 28a-f show inciffed at 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 10 Yes 2 No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda r than "natural", or items 23a or the Wedical Examiner must be a 220 Funeral death Wes Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11 Menta/Status Bleck, White, etc. filed within 72 hours efter Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No if Yes, Give Yaar or Datas: 1 Yes 22 No Baltimore, Maryland 21215-0020 Specify: Specify: B ð 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4sy 5+) ndary (0-12) 20/er Orkea d other 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Vierria 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 09 permit. Pages 1 end 2 s Department of Health er Important: If item 27 is eny injury or other trau ance. BALTO, MP. 21216 Merrian AFAYETTE AVE 220311 Mother GARRETT 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete WESTERN 21. Signature of Funeral Service Licansee 22. Name end Address of Facility BERG Wylu GILHOR BAUTNORY ND 21217 Approximate Interval Between Onset and Death Part1. Entar the disaasa, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiac or raspiretory errest, shock, or heart failure. List may one ceuse on aach line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Couse (Diseese or injury that initiated events rasulting in deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequença of): as attending BSF signed by the a Pert It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, à 24b. Were autopsy findings eveileble prior to completion of causa of death? 24a. Wes en eutopsy performed? Completed this cartificate has ral director, page 2 10 Yes 2 No The TES 2 No Hospital or Attending Physician: 24 hours aftar deeth. funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other (Specify) 2 2 No 1 ☐ Inpatient 2 🕅 ER/Outpatient 3 ☐ DOA 1 Yes 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey 28b. Time of 28d. Describe how Injury occurred Certification: After Injury 1 Neturel 5 Pending ret 3/29/98 1 Yes 2000 investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Zood Elmadon 3 ☐ Suicide 4 Homicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the ... within 24 hours vithin 24 hours To the Funeral D' Baltinoge dipy (as street 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) 29e Certifier Medicai and manner steted. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 29c. Licanse number MARCH 30, 1998 OCME

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32.

THE ODONE M. King

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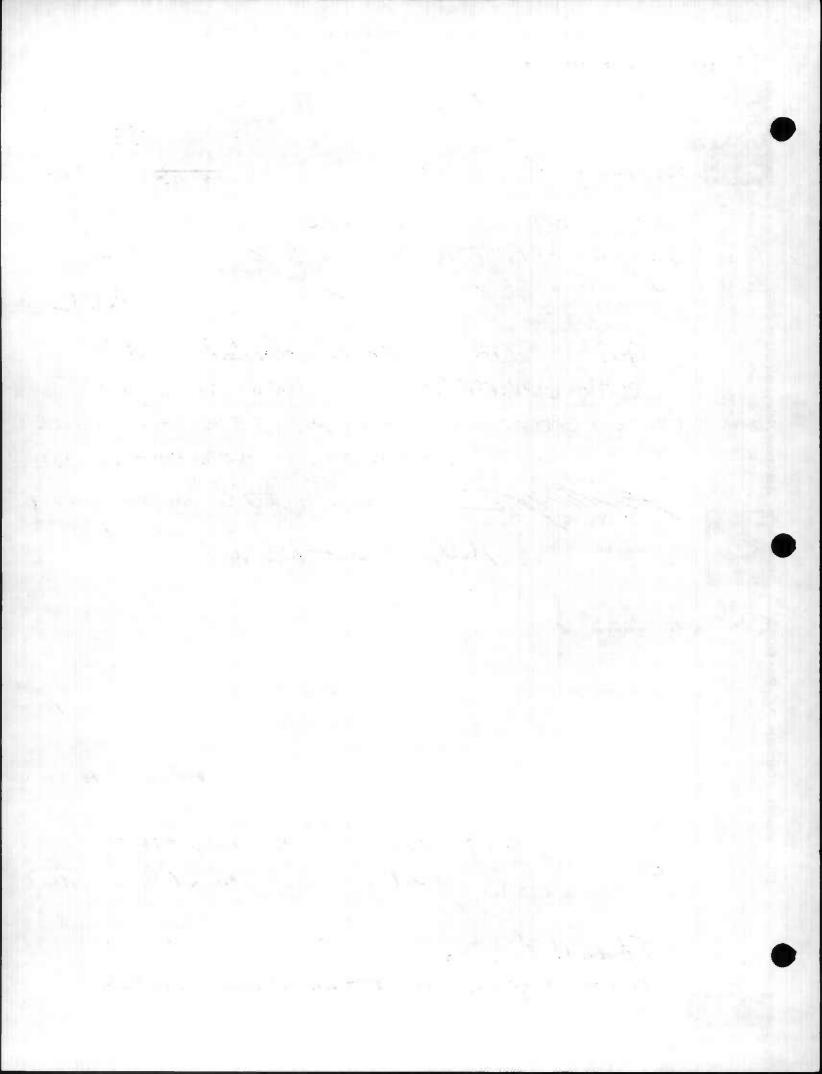
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helle Davidson Randolle

Registrer's Signature

BALTIMORE, Md. 2120

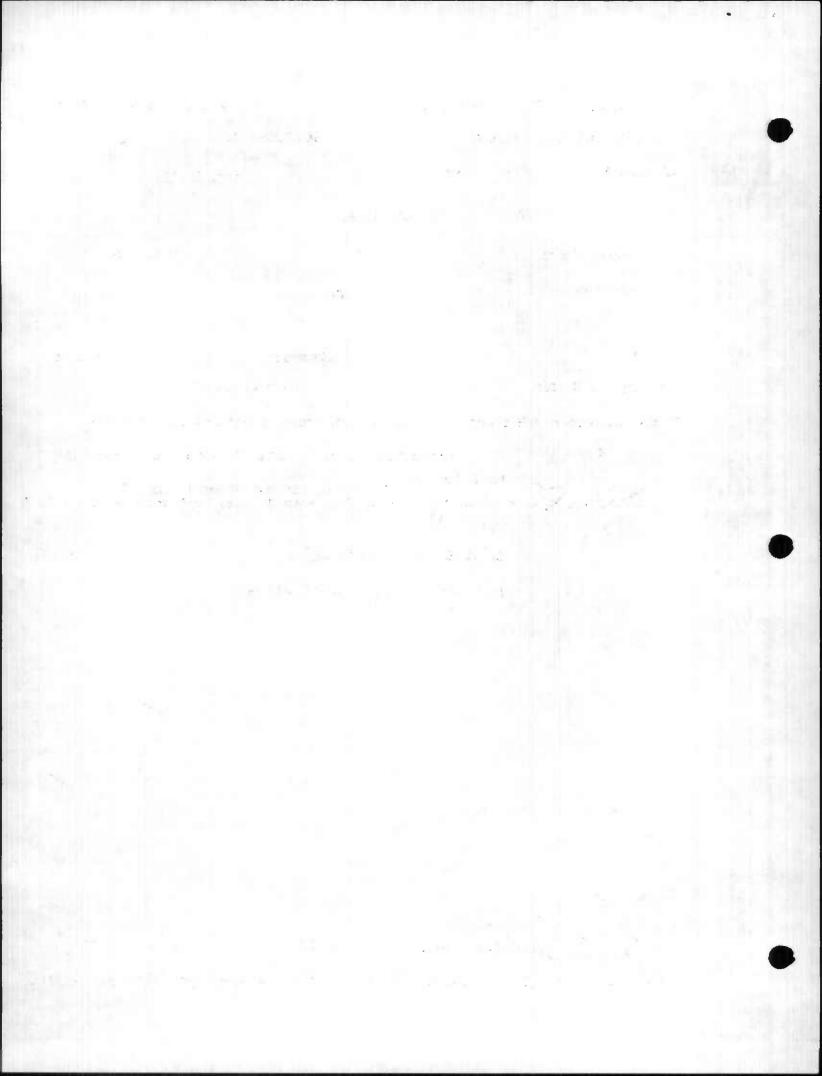


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State of Maryland / Department of Health and Mental Hygiene 8 10362

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Examiner	4e Facility Name (If not Institution THE JOHNS HOPK					4b. City, Town, o	or Location of Dee CE CITY	4c. County of Death				
Funeral Director	5. Social Security Number 235–66–8265	6. Sax 1 ☐ M 7 5 F	ga (In yrs. last birt		If Under 1 Year Months Deys	If Undar 24 H Hours Mi	in. (Month, D	irth Pay, Year) 24,1943	9. Birthi	place (State or Foraign ntry)		
72 hours after death with the Maryland natural; or items 23a or 23a-f show size Examine main to nowfied at steed by Funeral Director	Usual Rasidance of Dacedent 10a. Stata 10b. County NC	N/A	10c. City, Town		ition 111e, NC					10d. Insida City Limits 1 ☐ Yes 2 🎇 No		
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3a o	334 Tartan Co	art			28311			United States				
al; or items 23a or 28a-1 show Examinet must be notified at by Funeral Director	11. Maritai Status 1 Navar Married 20Mai 3 Widowed 4 Divorce	If Yas Giva	?	S. 13. Was Decedant of Hispanic Origin? (Spif Yas, specify Cuban, Maxican, Puarto			(Specify Yes or Narto Rican, atc.)	o- 14. Rac Blac Specify	ck, Whita,	can Indian, etc.		
ygiene. ner than "natural", t, the Mexical Exa Completed by	15. Deceder (Specify only higher	nt's Education est grade complated)	d) 16a. Decedent's Usual Occupation (Giva kind of work done during most of work lifa. DO NOT use relined)					16b. Kind of B	usinass/In	ndustry		
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	19a. Informant'e Name/Ralation Thomas W. Huste	Stata, Zij 2831										
Important: If itam 27 I any injury or other tri once.	20a. Method of Disposition 1 Burial 2 Remetion 4 Donation 5 Other (3 □Ramovai from Stete	20b. Place of cematar	Disposit y, crama		ce)	Data 1 3, 199	Data 20c. Location - City or Town, Stata				
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page 2 should be detected by P								24a. Was an autopsy performed? 24b. Were autopsy fir evelleble prior to completion of ca of death?				
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certificate rector, pag	25. Was casa rafarred to madical exeminar?				1		Daath (Chack only	ona)				
S D	1 ☐ Yas 2 € No	Hospital:	ant 2 ER/Out	tpatient	3LI DUA		Homa 5□Re	sidance 6 Oth	nar (Speci	ify)		
at Director: After the din by the funeral Certification:	27. Mannar of Death 1 Natural 5 Pendi 2 Accident Invast 3 Suicide 6 Could 4 Homicide datan	not be 28a. Piace of In	jury - At home, fai	njury		Yas 2 No						
within 24 hours after of to the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) Certifyi Certifyi Certifyi Certifyi	ng Physician: To the best Examiner: On the basis of and menner s	of axamination and	, death o	occurred at tha ti stigation, in my o	me, data and pla opinion, daath oc	ace, and due to the	e cause(s) and m e, date and place,	anner as	stated. to the ceuse(s)		
To the	29b. Signature and title of cestion	//	MD		29c. Licens		- 4	29d. Data signe				
10	30. Nama and address of person	o Tollars Ho	WICINS MI	NCal	rint) OGY	600 N. 0	boliti	ST BOL	TIM	1998 ORE MD		
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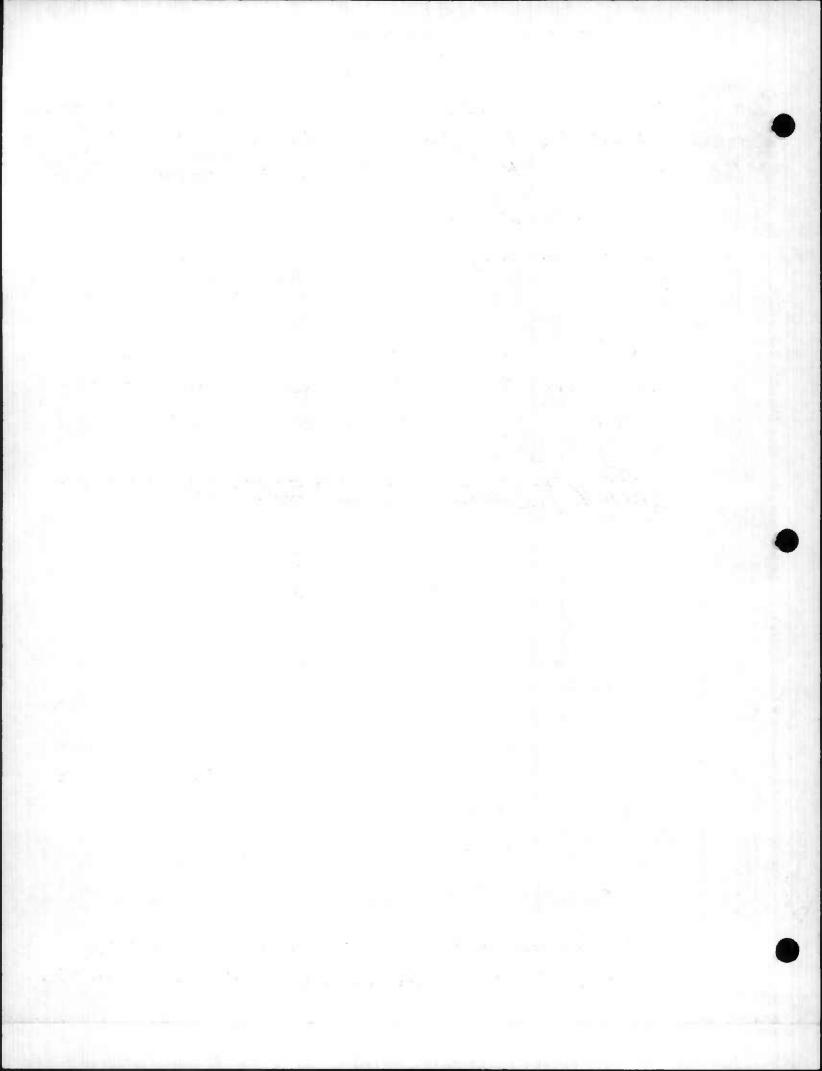
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** BAGY GiV Hernandez 98 10:07 A /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Dring Resional H-spilal Laurel Laurel If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthdey) Birthpieca (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 25 F Months Deys Hours none Yrs. Director 29 2/19/98 Maryland Usuel Residence of Decadent 10e. Stete 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Prince George's Laurel 10e Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 704 Gorman Avenue, Laurel 20707 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Detas: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1X Yas 2 No Specify: unknown Specify: Hispanic by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be If Item 27 is marked or antonic Villa Fuerte Miriam Hernandez ubed 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GormanAVe. 103 Loury Mother mD 2070 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donetlon 5 X Othar (Specify)in state 21. Signature of Funeral Service Licensee Ronald Sy Wade 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Peli Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, show, or heert feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medicai Immediate Ceuse (Finei Immeter disaase or condition resulting in death) Examiner Physician/Medical Examiner pretem physician and s the burial-transit The death certificate be executed Sequentially ilst conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Due to (or es e consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to þ 24b. Ware eutopsy findings evaileble prior to completion of causa of death? 24a. Was an eutopsy performed? Completed **DAGS 2** 1 ☐ Yes 💥 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No edical Certification: To 報 27. Manner of Deeth 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Ahiir 1 Naturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 No 2/19/98 Director: 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) after A 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et tha time, dete and piece, end due to the ceuse(s) end menner as stated.

| Medical Examinar: On the best of exemination and/or invastigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) 29e. Certifian To the Hor within 24 h To the Fur completely and manner stated. 29d. Data signed (Month, Dey, Year) 29b. Signatura and title of certifian 29c. Licansa number Quilom, MD. D44724 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 4116 HOWARD RD. BETSVILLE, MD 20705 Quilon Helmy 32. Registrar's Signature Randall 31. Dete filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95



98-1702-510

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HARVEY HEARD				State of Ma	arylar				lealth and N Death		giene9 8 Reg. No.		0364
TILLAND		1. Decedent's Nem	e (First, Middle, La	st) 4	-					2. Date of De			3. Time of Death
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- /Medic		4s Feelity Name (12 V	e street and number)					4b. City, Town, or L				
Examin	er	908 N.LU							BALTIMO			WA	
		5. Sociel Security N			/In vrs	. lest birthday)	If Under	1 Year	If Under 24 Hrs.		th	9 Birt	hplece (State or Forei
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the M	9	10e. Street and Nu	mber	/ /		1/11/1	10f. Zip	Code			10g. Citizen of	What Co	untry?
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eath w	era	11. Mantal Status	11. LU2	12. Wes Decedent E	ver in t	J.S. 13. V	/es Dece	dent of F	tispenic Orlgin? (Si	pecify Yes or No	- 14. Ra	ca - Ame	rican Indian,
	5		ied 2□ Merried	Armed Forces? If Yes, spec			cify Cub	tispenic Orlgin? (Si en, Mexican, Puert	Rican, etc.)	Ble	ck, White	e, etc.	
hours after	by F	3 Widowed		If Yes, Give		1	☐ Yes	2 No	Specify:		Specif	y: 93/	NK
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		23a. Party. Enter	disease, or com	plications thet caused one cause on each lin	the dee	eth. Do not ente	or the mod	de of dyi	ng, such es cardiac	or respiretory e	rrest,		Approximate
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State Registrar

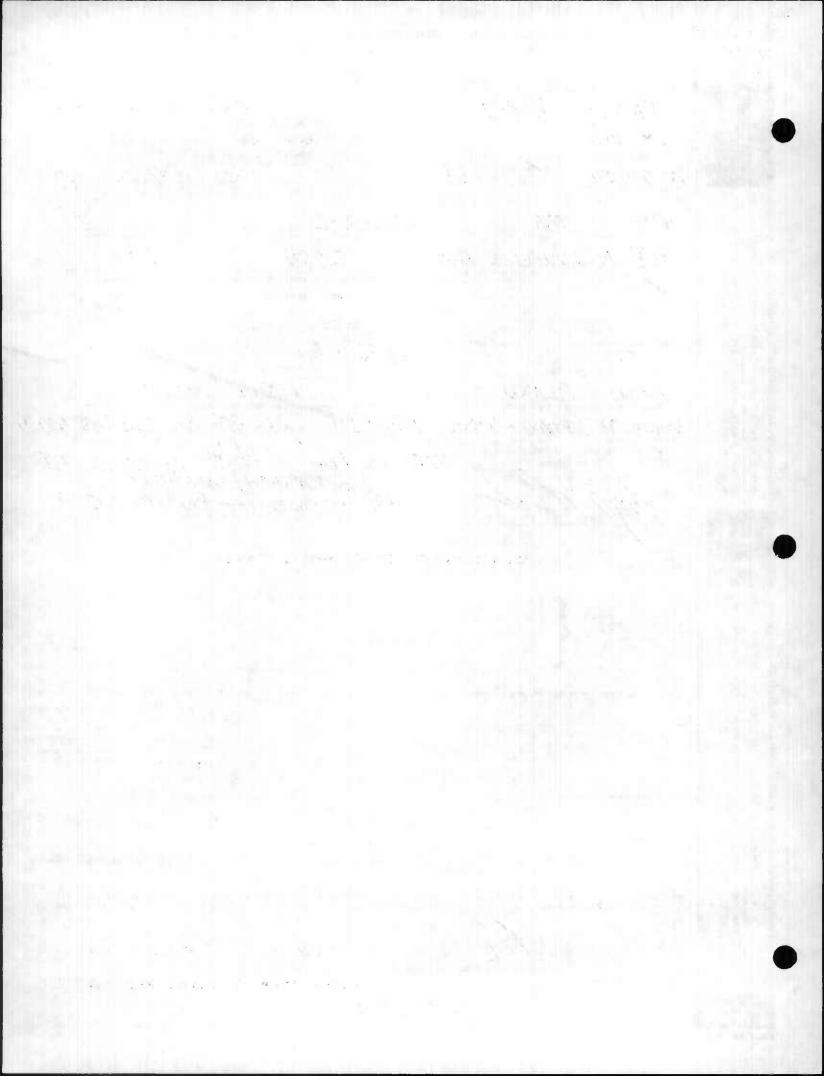
DAVID R. FOWLER M.D. 31. Dete filed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

MARCH 26,1998



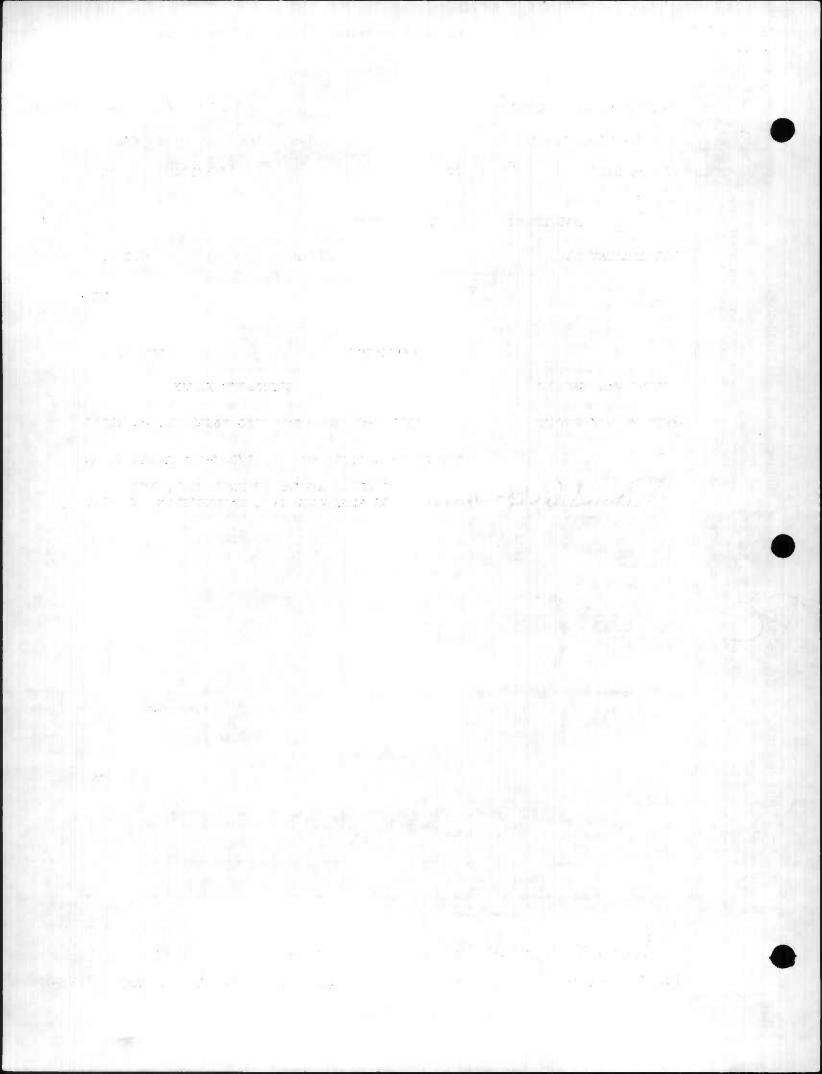
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BERNICE Items: 23 part I, II, 27, 28a-f per MEO 4/15/98 Certificate of Death HARGETT 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 25, 1998 BERNICE FRANCES HARGETT 11:00A.M. MARCH /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner UNIVERSITY HOSPITAL BALTIMORE N/A If Under 1 Yeer 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 10 M 2 F Months Days Hours Min Yrs. 220-24-3472 92 06/01/1905 MD Director Usual Residence of Decedent the Maryland r 28a-f show 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director BALTIMORE MD CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1 r than "naturel", or items 23s or the Medical Examiner must be r 711 ACADEMY LANE 21228 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Stetus Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene.
Int: If from 27 is marked other than "naturel; or fre 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 Specify: WHITE 1 Ves 2 XNo Specify þ 3 Ø Widowed 4 □ Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 18 Mother's Name /First Middle Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be marked FRANK Von MUNCHOW ELIZABETH SENFT 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) HENRY FONES/BROTHER 1917 ORCHARD POINT ROAD PASADENA, MD 21122 other 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Depentment of important: If it eny injury or o 1X Buriel 2 Cremetion 3 Removel from State OUDON PARK CEMETERY 3/28/98 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility STERLING ASHTON FUNERAL HOME, INC. NOOPIL 736 EDMONDSON AVE. CATONSVILLE, MD 21228 Approximete Interval Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Immediate Cause (Finel disease or condition resulting in death) /Medical . COMPLICATED BY FRACTURES OF OSTEOPOROTIC LOWER FEMORA Examiner Due to (or es a consequence of): Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequença of): 68760 Physician/Medical Due to (or es e consequence of): Box 950 for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown 3 ALZHEIMER'S DISEASE law requires that signed t by Records, 24b. Were eutopsy findings eveilable prior to been signature 24e. Wes en eutopsy performed? Completed completion of cause of death? hes page 1X Yes 2 □ No 1X Yes 2□ No certificete Division of Vital Physician: 25. Wes case referred to medical examiner? director, Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1⊠ Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this funeral 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) After 5 Pending Investigation Attending 1 Netural 1 Yes 2 KNo Subject fell death. found 3/23/98 found 20 Accident Director 28f. Location (Street end Number or Rural Route Number, City or Town, State Frederick Villa Nursing 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) in 24 hours the Funeral Direc-the filled in br 3 4 Homicide ŏ Found: Nursing Home 1127 Granville Rd., Balto., Md. edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. 29a. Certifier Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only To the within 2 To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 27, 1998 ypie O.C.M.E. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) A. LONOU DO LOW 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State APR 0 2 1998 ia Davidson-Randalle

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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by Funeral Director	111	s erried 21⊠ Married d 4 □ Divorced	Armed Force 1 Yes 20 If Yes, Give	Ves Decedent Ever In U,S. Immed Forces? ☐ Yes 2 ☑ No Yes, Give feer or Detes: 13. Was Decedent of Hispanic Origin? It Yes, specify Cuban, Mexicen, Put 1☐ Yes 2 ☑ No Specify:				Sansit:			
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Medical Certifi	29a. Certifier (Check only one)	1 Cartifying 2 Medical Ex	Physician: To the bes aminar: On the basis and manner	ot examine	owledge, deeth oc ation and/or invest	curred et the	e time, date end plecay opinion, deeth occ	e, end due to the curred et the time,	ceuse(s) and n date end pleca	nanner as s , and due t	stated. to the ceuse(s)
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د	30. Neme end ed	Idress of person wh	no completed cause of	f death (Iter	n 23e) (Type, Prir	nt)					

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Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) Month ohnson HERMAN 7.45 PM James MARCH 998 26 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Deeth Hospital Ballmore, MD Agnes N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Yrs. JUNE 215-30-9440 63 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Anne Arundel Linthicum Heights 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 32 Governor's Gate Lane 21090 USA 14. Race - American Indien, Bleck, White, etc. 12. Was Dacedant Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Truck Mechanic John Ritter 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Frederick William Johnson Virgie Marie Cooney 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Anna Johnson - wife 32 Governor's Gate Lane, Linthicum Hgts., Md. 21090 20b. Place of Disposition (Name of cematery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stata 3/30/98 1 DeBurial 2 Cremation 3 Removal from State Elkridge, Md. Meadowridge Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Euneral Sarvice Llo 22. Name end Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP Incl. cen 7250 Washington Blvd., Elkridge, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina. Approximate interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) 8 MONTHS SMALL CELL LUNG CANCER Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or es e consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of deeth? Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 2 Accident

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JOHNSON

JAMES

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filled within 72 hours effernant of Health and Mental Hyglene.
int: If Item 27 is marked other than "naturel; or ite

Department of Health e Important: If Item 27 Is any Injury or other tra

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Examiner

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25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1- Natural

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Yes 2 No

 Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 🗠 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceusa(s) and manner stated.

29b. Signature end title of cartifier

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29d. Date signed, (Month, Day, Year) March 26, 1998

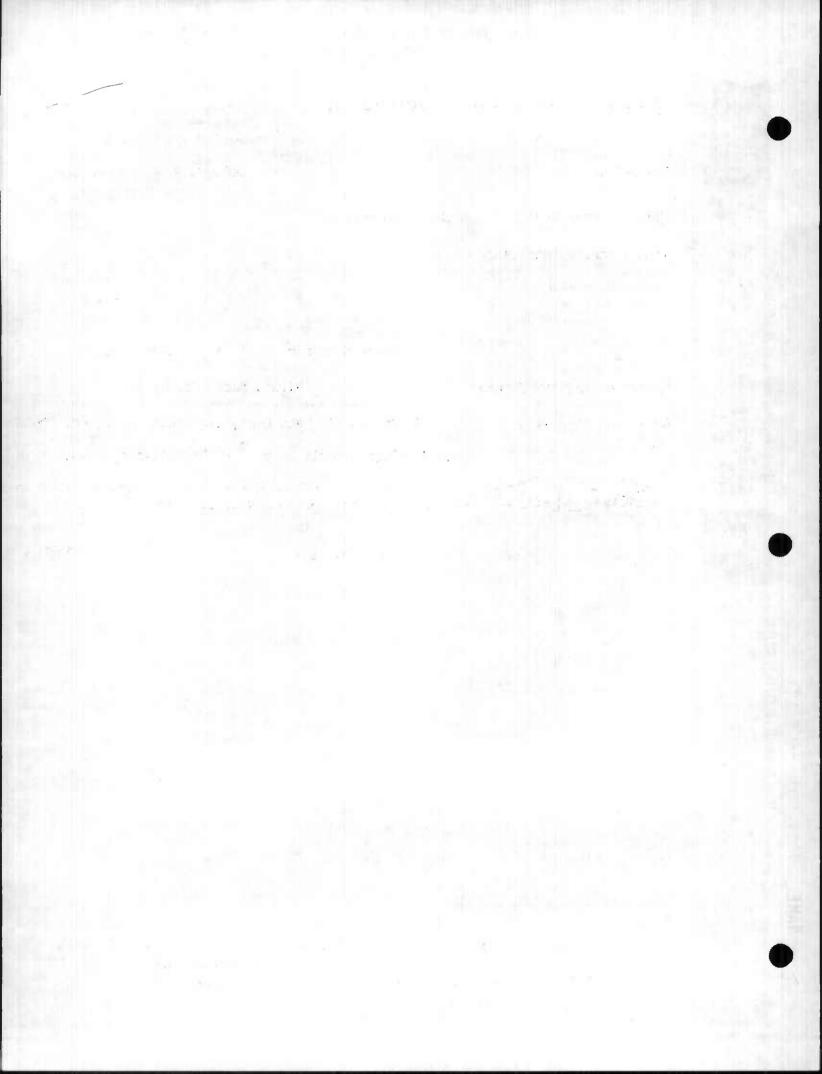
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) ST. AGNES HOSPITAL 900 CATON AVE

PINTAVORN, MO PAIRACH BALTIMORE,

State Registrar 31. Date filed (Month, Day, Year)

0 2 1998





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 11:25 AM 1998 30 March 5 Geneva Janes 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital BALTIMORE SINOI If Under 24 Hrs. If Under 1 Year 5. Sociei Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Months Deys Hours Min. 10M 20F 73 Yrs. Apr. 23, 1924 Mary 1 AND 2/6-24-97/1 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No BALTIMORE Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KU AD 3518 Ellamont 2/2/5 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried specify: Black 1□ Yes 2□No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) TEACHER SCHOOL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WATKINS Smith, Ascilla 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3 7 7 0 19a. Informent's Neme/Reletionship (Type, Print) WNES cupy EENBELT, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cremation 3 Removal from State 106500 4 ☐ Donation 5 ☐ Other (Specify) Rost CEmetery 22. Name and Address of Facility CHATMAN-3240 REISTENSTOWN PUMS 21. Signature of Funerei Service/Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Thorucoahdominal Due to (or as a consequenca of): month Gastro intestinal Due to (or as a consequence of) month Preumonia Due to (or as a consequence of): 23b. Did tobacco uaa contributa to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No

Physician /Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itsm 27 is merked other than "natural", or items 23a any injury or other traumatic event, and the

Baltimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records,

Directo

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

24a. Was an eutopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2 No

1 Yes 2 No

25. Was case referred to medical exeminer? 1 Yes 2 No

Hospital: 28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Impatient 2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurred

29a. Certifier (Check only one)

27. Manner of Death

2 Accident

3 ☐ Sulcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the tima, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d, Date signed (Month, Dev. Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

more

APR 0 2 1998

5 Pending

investigation

6 Could not be

A1-2402321 JR9444

March 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai

TROSemore 31. Date filed (Month, Day, Year)

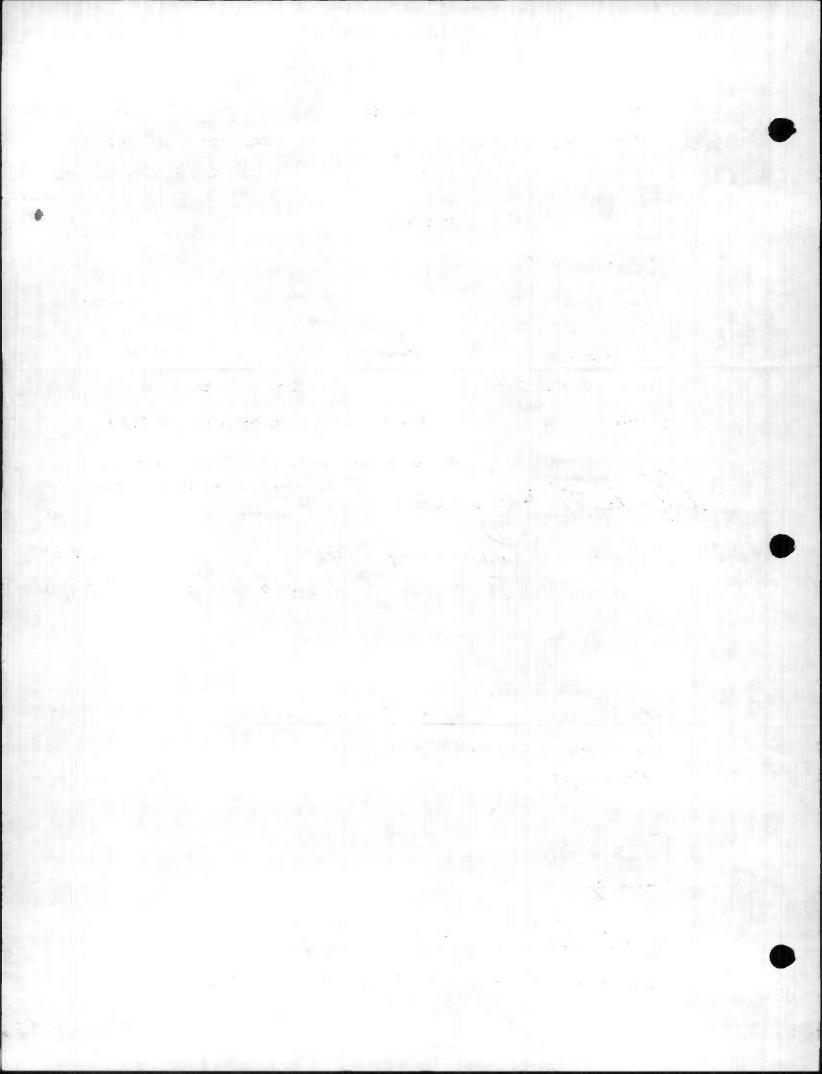
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State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Š	11. Marital Status		2. Was Decede Armed Force 1 ☐ Yes 2	s?	,s. 13. v	Yes, spec	cify Cuba	n, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	0-	Biack, White		
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0 00	John E. Shin	ndelede	ecker					Clara	B. Yates				
	19a. Informent's Name/Reia	ationship (Typ	oe, Print)		19b. Mailin	g Address	(Street a	nd Number of	r Rural Route Num	ber, City or	Town, State, 2	Zip Code)	
	Mr. Robert K	Kalende	ek		8908 M	Mayfl	ower	Road;	Baltimor	e, MI	21237		
	20a. Method of Disposition				Ptace of Dispos	sition (Nar	me of		Date		cation - City or	Town, State	
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	4 Donelion 5 Other (Specify) Sacred Heart of Jesus Cem. 3/28/98 Balto., MD 22. Name and Address of Facility Kaczorowski Funeral Home; 1201 Dundalk Ave.												
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5	Denens	MA							10	Yes 2	gno	1 ☐ Yas 2	□No
Be	25. Was case referred to me examiner?							26. Place of	Deeth (Check only	one)			
0	1 ☐ Yes 2 No	Н	ospital: 1 XInp	atient 2	ER/Outpetien	t 3□ D0	OA Othe	er: 4 🗆 Nursir	ng Home 5□Re	sidence 6	Other (Spe	city)	
	27. Manger of Deeth	ending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	2	28c. Injun Work	at c?	28d. Describ	a how Injur	y occurred		
- 1	2 ☐ Accident in	rvestigation				М	1 🗆 '	Yes 2□No					
		could not be letermined	28e. Place of building.	Injury - At h etc. (Specia	ome, farm, stre	eet, factor	y, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier	etifidas Dhus	lolen. To the he	et of my bee	uviadas daeth	o o o u read	at the tim	o data and n	lace, end due to th	0.00000(0)	and manner or	hotels	
ii Cerinican		dical Examin	er: On the basis	s of examine	etion end/or inv	estigation	, In my op	pinion, deeth o	occurred at the time	e ceuse(s)	place, and dua	to the cause	(s)
dical Certificat	(Check only 2 Merone)					1	c License	number		29d. Dat	e signed (Mont	h. Dav. Year	
	(Check only 2 Me	office /				290	o. Cicorise					.,	
	(Check only 2 Me	Oh	_ m.	2		100			409	3/2	5/98		
Medical Certification:	(Check only 2 Me	orson who con			m 23e) (Type, I	100			409	3/2	5/98		
	(Check only 2 Medione) 29b. Signature and tale of	erson who con			m 23e) (Type, I	100			409 2 Many	3/2	5/98		

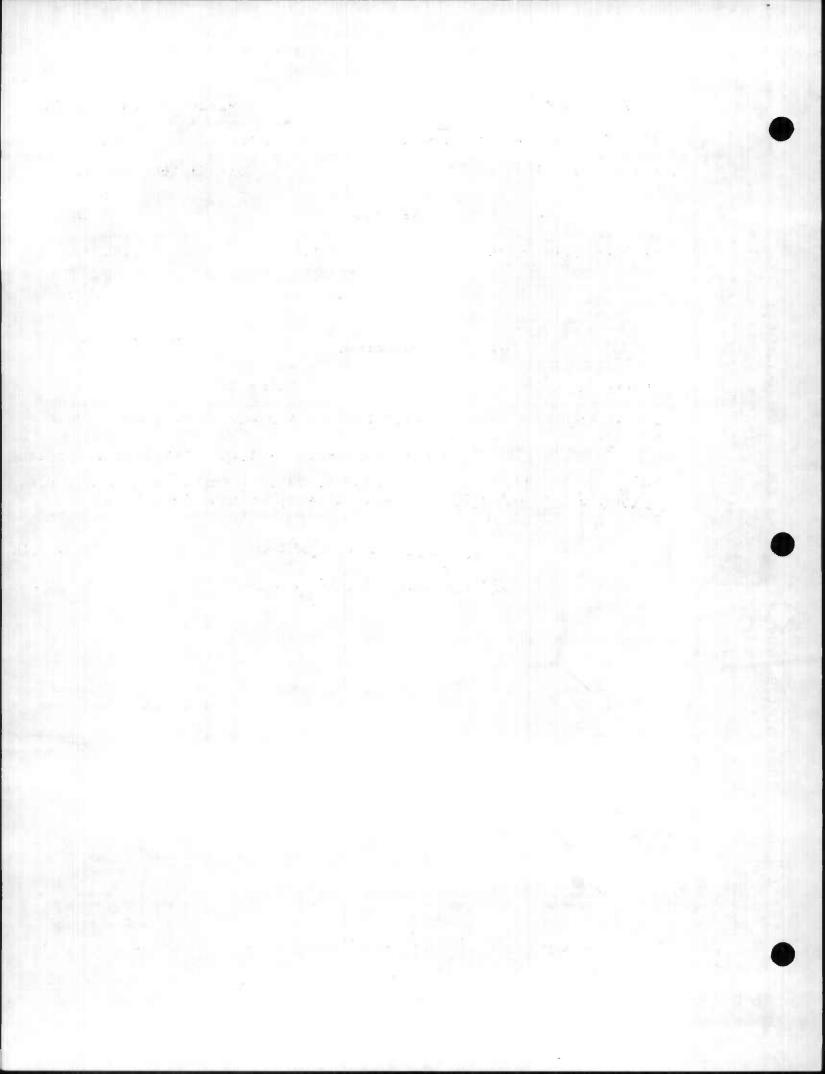


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State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / B	Certificate of	Death	Reg. No.	38	0370	
П	Physician	1. Decedent's Name (First, Middle, Last)			Mo	e of Death onth Day	Year	3. Time of Death	
	/Medical	BRYAN KOGER 4a Fecility Name (If not Institution, give str	, 1998 County of Death	2:00pm					
	Examiner	4110 Ethland A	The same of the sa		Baltimore	51 Death 40, 0	n/a		
-	Funeral Director	5. Social Security Number 6. Sex 120 A	7. Age (In yrs. last birtl		If Under 24 Hrs. 8 Dat	e of Birth ynth, Day, Yeer) 22/196!	9 Right	olece (Stete or Foreign http) yland	
	pue *	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			1	Od. Inside City Limits	
	4 eho				Yes 2□No				
	ter death with the Meryler Herrs 23s or 25s-1 show the must be notified at Tuneral Director	10e. Street and Number 4110 Ethland A	en of What Cour	itry?					
ozo urs af ur, or by F	1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	. Wes Decadent Ever in U,S. Armed Forces? 1 _ Yes _ 2\overline{\text{ZN}} No ff Yes, Give Yeer or Detes:	13. Wes Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	ispanic Origin? (Specify Yean, Mexican, Puerto Rican, Specify:	etc.)	4. Reca - Americ Black, White, Specify:			
5-0	ed within 72 hours ygiene. Mr than "natural", ft, the Medical Exy Completed by	15. Decedent's Educa (Specify only highest grede of	tion 16a.	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired	ation during most of working	16b. Kind of Business/Industry			
121	within than " than " than " and the complex than the comp	Eiementary/Secondery (0-12)	College (1-4or 5+)	iife. <i>DO NOT</i> use retired Comoter	3)	Mus	sic/Dis	cos	
	三工五日	12th 17. Father's Neme (First, Middle, Last)	2+	O.M.O.O.C.I	18. Mother's Name (First,	Middle, Meiden S	Sumeme)		
ian	Saby Q				Alice J.	Koger			
Maryjand	AS DE L	19a. Informent's Name/Relationship (Type	o, Print) 19b.	Mailing Address (Street	Town, Stete, Zip	Code)			
-	and alth	O'Neal Koger	41	10 Ethlan	d Avenue,	Balto.,	, MD 2	21207	
Baltimore	0 % 5 2 2	20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State cemeters	Disposition (Name of r, crematory or other pleat Crematory			ation - City or To	own, Stete , Marylan	
68769	Physician /Medical Examiner	Cause (Disease or Injury that Initiated events resulting in death) Lest	Seizur	on sequence of):	ss of Facility DYETT & S perty Heigh g, such es cardiac or respi	ts Ave.	,Balto	DME, P.A. D., MD Approximate Interval Between Onset and Death 10 munute 12 ylars	
Вох	at the death cert by the ettendinetached for use Physician/M	_ 0					1		
o.	res that the designed by the ellips detached for the by Physic	Pert ii. Other algnificant conditions contri	buting to death but not resulting in	the underlying cause give	ren in Part I. 23			o the cause of death? bably 4 Unknown	
Д,	ss that gned b be dete by PI					1 TOS 21	ZNo 3□Pro	DEBTY 4 OHKHOWN	
Records,	been should				24	a. Was an autops performed?	ev	ere autopsy findings valleble prior to empletion of cause death?	
Œ.	The lew pege 2					1□ Yes 2 🗷	No 1[Yes 2E No	
Vital		25. Was case referred to medical examiner?			26. Place of Death (Chec	k only one)			
o	hys his I di	1 Yes 2 No	spital: 1 Inpatient 2 ER/Out 28a. Date of Injury (Month, Dey Year) 28b. T	ime of 28c. Injury	y at 28d. Do	Residenca 6		(y)	
Division	tel or Attending P rs efter death. at Director: After tel led in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Pleca of injury - At home, far building, etc. (Specify)		Ce 28f. Location (Street end Number or Rural Route Number, City or Town, State)				
	Hospi 24 hour Funer stely fill	29a. Certifier (Check only one) 1 Certifying Physic 2 Madical Examination	ian: To the best of my knowledge, r: On the basis of examination and and manner stated.	death occurred at the tin /or Investigation, in my o	ne, date end place, and du- plnion, deeth occurred at th	e to the cause(s) one time, date and	and manner as s place, and due t	itated. o the cause(s)	
	within 2 To the comple	29b. Signature and title of certifier	3 R.	29c. Licens	1		signed (Month,	10	
	. 1	Lama	< / Junch		22114			3, 1998	
	4	30. Name and address of person who com	pleted cause of deeth (item 23a) (FDERICLE ROA		MIAN E. 18 BALTI			YLAND	
	State Registrar	31. Dete filed (Month, Day, Year)	39. Begister's Signature R	ndelle	,				

DHMH 16 Rev 6/95

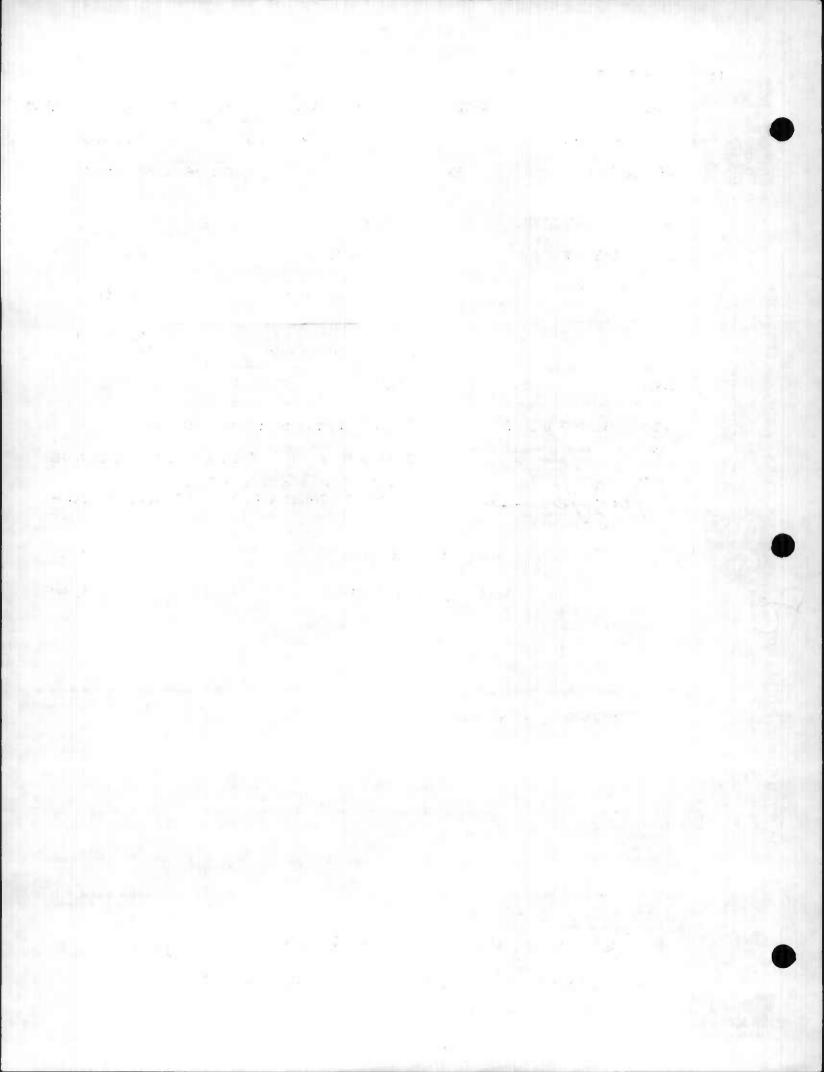


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#8 per FH G758 4/6/98 EW Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year **Physician** IRVIN LEVINSON MARCH 30 1998 12:15 AM BARRY /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner 2016 JOLLY RD. BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Hours 49 FEB. 16,61949 Director 264-84-9234 MARYLAND Usuel Residence of Deceden permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other trsumatic event, in Medical Examine must be notified at the 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2016 JOLLY RD. 21209 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian 11. Meritel Stetus Bleck, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifyHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) SOL LEVINSON & Elementery/Secondary (0-12) College (1-4or 5+) 4 VICE PRESIDENT/OWNER BROS., INC. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Н. LEVINSON PHYLLIS FINE **JACK** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) BALTIMORE, MD 21209 SUSAN LEVINSON (WIFE) 2016 JOLLY RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete Murial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW 4/1/98 REISTERSTOWN, MD ce of Funeral Service Liganses 21, Signal SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ermson e, of complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final 1 dey myocordial infarction disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner lyeor Coronery antery disease
Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initioted events resulting in deeth) Lest Records, P.O. Box 68760, physician s the buriel Physician/Medicai Due to (or es e consequence of) the deeth certificate 88 USB ö signed by the a d be deteched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown The law requires thet moderate corte stemosis þ 24b. Were autopsy findings aveilable prior to completion of cause of death? should I 24a. Was en autopsy Completed s certificate hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, or Attending Physician: Be 25. Wes cese referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred After 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Hospital 29e. Certifier 12 Cartifying Physictan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. edicai 2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. (Check only one) the th 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 2 D 20604 Kichado Bay in 3/30/98

Registrar

Richard A. Seg. & D; 10755 Folls Rd; Svite#450; Luther ville, Hal 21093 32 Registrars Signature 31. Date filed (Month, Day, Year) APR 02 1998

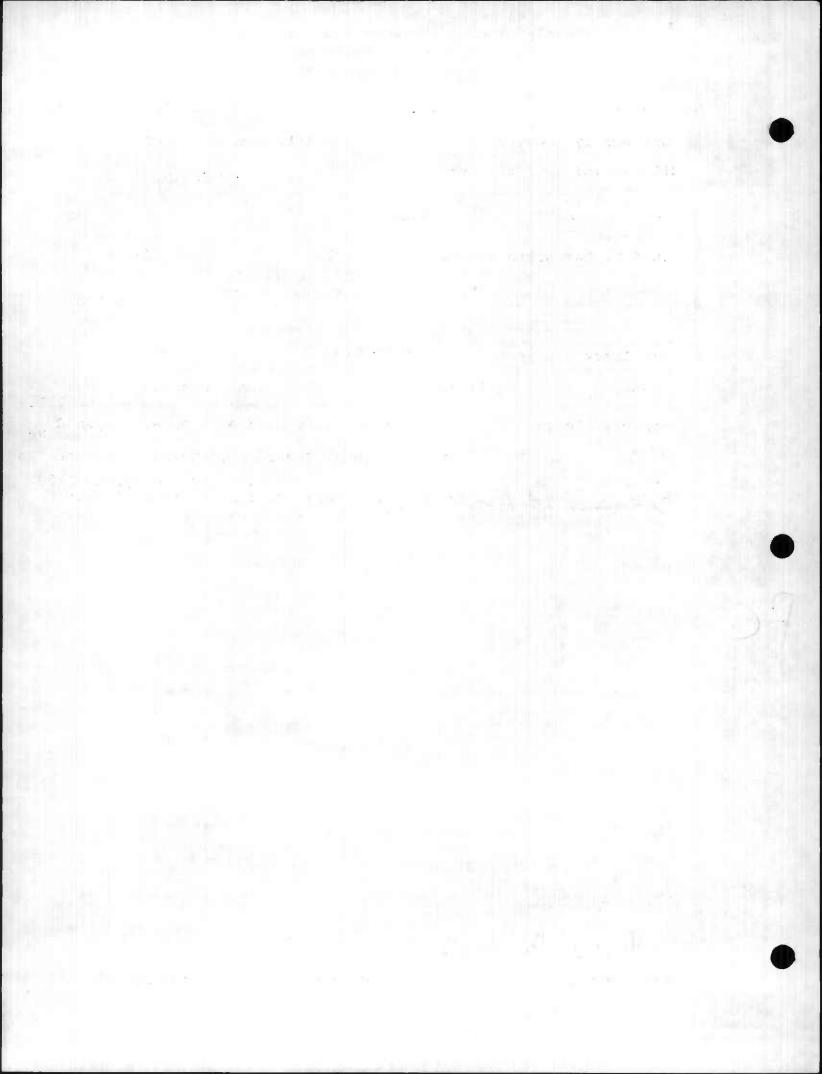
30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)



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	Items: 23 part 1	1,27,28	Ba-f per	MEO G-758	3 4/8 /98	Tilicate of	Death	2. Date of D	Reg. No.		3. Time of Death
n il	Vernadin			Lı	ıcas			Month Marc	Oay	Yeer 98	10:27an
4	te Facility Name (If not insti			nber)			4b. City, Town, or			y of Death	
-	University 5. Social Security Number	y Ho:		7. Age (In yrs.	last hirthday	If Under 1 Year	Baltime If Under 24 Hrs		NA	0 Riethole	ana /Stata or Enraine
	216-52-258	3 1	M 2√2 F	48	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Counti	nce (Stete or Foreign y)
-	Usuel Residence of Decede 10a. State 10b. Co			10c. City	y, Town or Lo	cation				10	d. Inside City Limits
Md NA Baltimore 10e. Street and Number 10f. Zip Code											1 ☐NYes 2 ☐ No
	10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?		
	1024 N. C.	arro	lton A	venue		2121	7		USA	A	
11. Maritel Status 1 Never Married 2 Married 12. Was Decedent Armed Forces? 1 Yes 2 Wif Yes, Give			ces? 2 No	1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 A No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Ricen, etc.)	o Ricen, etc.) Black, White, etc.			
	3 Widowed 4 Divo	Yeer or Da						Speci			
15. Decedent's Education (Specify only highest grade completed)					16a. Deced	dent's Usual Occup kind of work done	oation during most of word)	rking	16b. Kind of E	Business/Indi	ustry
	Elementary/Secondary (0- 9th Grade	,	College (1 NA	-4or 5+)		nployed	0,		NA		
•	17. Father's Name (First, Mic		7417				18. Mother's Nar	me (First, Middle	, Maiden Suma	me)	
	James		Wil	liams					rcell		
	19a. Informant's Name/Rela	ationship (7	ype, Print)		19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	ber, City or Town	n, State, Zip (Code) 2121
		Coop	er	001 0			ffe Roa				
2	20a. Method of Disposition XIXBurial 2 ☐ Crema	ition 3 🗆	Removal from S	0	emetery, crer	sition (Name of natory or other pla		Date	20c. Location		
	4 Donation 5 Oth		_	MC	-		Cemete				imore Co
4	21. Signature of Funeral Ser	rvice Licen	18-	~		Name and Address	rch FH			_	d 21202 nue
-	23a. Part 1. Enter the diseas shock, or heart fallure.	se, or com	lications that or	used the deal							Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) NARCOTIC AND ALCOHOL INTOXICATION										Onset and Deeth	
Due to (or es e consequence of): b. Sequentially list conditions, If the conditions of the conditions of the consequence of											
	Sequentially list conditions.		b	Due to (o	ras e conseç	juence of):					
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of):											
4			d								
	Date of the Manager	- dial		- th. h	dal 4 - At			L cot Dis	I Ashrana nasa		AL
1	Pert II. Other significant conditions contributing to death but not resulting in the underlying cau						ven in Part I.		Yes 25 No		the cause of death' abfy 4 ☐ Unknow
,									2 100 234110		
									s an autopsy formed?	ava	re autopsy findings ilable prior to apletion of ceuse eath?
								ōC)	Yes 2□No	130	Yes 2□ No
	111	adical					26. Plece of De	ath (Check only	one)		
2	Was case referred to me	edicai		. VY	ER/Outpatier	t 3 DOA Oth	ner: 4 Nursing h	lome 5 ☐ Res	ildenca 6 □Ot	ther (Specify,)
1.4	25. Was case referred to me examiner? XX Yes 2 No	-	Hospital: 1 ☐ II	npatient ZLA		28c Inju	ry at	28d. Describe	how injury occu	irred	
	examiner? XX Yes 2 No 27. Manner of Deeth		28a. Date o		28b. Time of Injury	A Wo		Unknown			
	examiner? XIX Yes 2 No 27. Manner of Deeth 1 Natural 5 Pour in in in in in in in in in in in in in	ending envestigation	28a. Date of	f Injury h, Day Year) /28/98	Injury Found	M 1□	rk? Yes 2∭TNo		(0)		5
	examiner? XIX Yes 2 No 27. Manner of Deeth 1 Natural 5 Po 2 Accident in 3 Suicide 6 & C	ending	28a. Date of (Month) found 3, 28e. Place building	f Injury h, Day Year) /28/98	Injury Found ome, farm, str y)			28f. Location	(Street and Number, State) 102	24 N. Ca	Route Number, arrollton Av
2	examiner? XXYes 2 No 27. Manner of Deeth 1 Natural 5 P. 2 Accident 3 Suicide 6 A C. 4 Homicide 29a. Certifier (Check only 2006)	ending evestigation could not be etermined	28a. Date of (Month) found 3, 28e. Place buildir found: relclan: To the hiner: On the ba	of Injury th, Day Year) /28/98 of Injury - At hong, etc. (Specific Residence best of my knows is of exemine	Injury Found ome, farm, str y) Ce wledge, death	M 1 □ eet, factory, office		28f. Location City or To	Baltimor cause(s) and m	24 N. Ca re, Md. nanneras sta	rrollton Av
2	examiner? XXYes 2 No 27. Manner of Deeth 1 Natural 5 P. 2 Accident in 3 Suicide 6 A C. 4 Homicide 29a. Certifier (Check only one)	ending ivestigation could not be etermined rtifying Phy dicaf Exam	28a. Date co (Month) found 3, 28e. Place buildir found:	of Injury th, Day Year) /28/98 of Injury - At hong, etc. (Specific Residence best of my knows is of exemine	Injury Found ome, farm, str y) Ce wledge, death	M 1 = eet, factory, office n occurred at the fivestigation, in my c	me, date end plece	28f. Location City or To	Baltimore cause(s) and moderate and place	24 N. Ca re, Md. nanner as sta n, and due to	errollton Av
2	examiner? XXYes 2 No 27. Manner of Deeth 1 Natural 5 P. 2 Accident 3 Suicide 6 A C. 4 Homicide 29a. Certifier (Check only 2006)	ending ivestigation could not be etermined rtifying Phy dicaf Exam	28a. Date of (Month) found 3, 28e. Place buildir found: relclan: To the hiner: On the ba	of Injury th, Day Year) /28/98 of Injury - At hong, etc. (Specific Residence best of my knows is of exemine	Injury Found ome, farm, str y) Ce wledge, death	M 1	me, date end plece	28f. Location City or To	Baltimor cause(s) and m	24 N. Ca re, Md. nanner as sta , and due to red (Month, D	ted. the cause(s)
2	examiner? XXYes 2 No 27. Manner of Deeth 1 Natural 5 P. 2 Accident in 3 Suicide 6 A C. 4 Homicide 29a. Certifier (Check only one)	ending evestigation to be determined the set of the set	28a. Date c. (Month found 3, 28e. Place buildir found: 1 relicion	of Injury b, Day Year) /28/98 of Injury At hing, etc. (Specify Residence best of my knows is of exemineter stated.	Injury Found me, farm, str y) CC wledge, death tion and/or in	M 1 = eet, factory, office n occurred at the fit vestigation, in my c 29c. Licens O • C	me, date end plece	28f. Location City or To	Baltimor Baltimor e cause(s) and m , date and placa 29d. Date sign MARCH	24 N. Care, Md. nanner as state, and due to 29, 19	arrollton Avited. the cause(s) Pay, Year)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 30 ANNA March MAYNARD 4b. City, Town, or Location of Deeth 4e. Fecllity Neme (If not institution, give street end number) ltimore Ta If Under 1 Year 8. Date of Birth (Month, Day, Year) SUNE 8, 1910 9. Birthplace (State or, Country) Country) Country CARCLINA 5. Social Security Number 7. Age (In yrs. lest birthdey) Deys Hours 1□ M 2□ F 213-18-3557 Yrs. Usuel Residence of Decedent 10b. County 10d. Inside City Limits 12 Yes 2 No MARYLAND NA 10e. Street and Number 10a. Citizen of What Country? 4639 MANOR DENE KOA 12. Was Decadent Eyer in U.S. Armed Forces? KOAD USA. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cyben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: BLACK 3 ₩Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+H GRADE DOMESTIC WORKER PRIVATE FAMILIES 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) WRIGHT BROOKS JAMES REBECCA 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MARY R. GREENE (DAUGHTER) 4226 COLBORNE ROAD, BALTIMORE, MD, 21229 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City of Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State EDAR HILL CEMETERY 3-30-98 GLENBURNIE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) Sharron Do JOSE P.H. H. BROWN JR, FUNERAL HOME 2140 N, FULTON AVE, BALTIHORE, HD, 212 17 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Immediete Ceuse (Finel diseese or condition resulting In death) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

signed by I

certificate

After

n 24 hours after death.

The Funeral Director: After pletely filled in by the fun

within 2

funeral

completely

Be

Certification: To

Medicai

Box 68760

P.O.

Records,

Division of Vital

the Hospital or Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

10e. Stete

Funeral

Director

Nem 27 is marked other than "natural", or Nems 23a or 28a-f ahow other traumstic event, the Modical Examiner maint by notified at

Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieled events resulting in deeth) Lest Completed by Physician/Medical the hh 88 980

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28d. Describe how injury occurred

25. Wes case referred to medical axeminer? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending

investigation 2 Accident 6 Could not be determined 3 Sulcide

28e. Dete of Injury (Month, Dey Year) 28e. Pleca of Injury - Af home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

26

(Check only one)

2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Dey, Year)

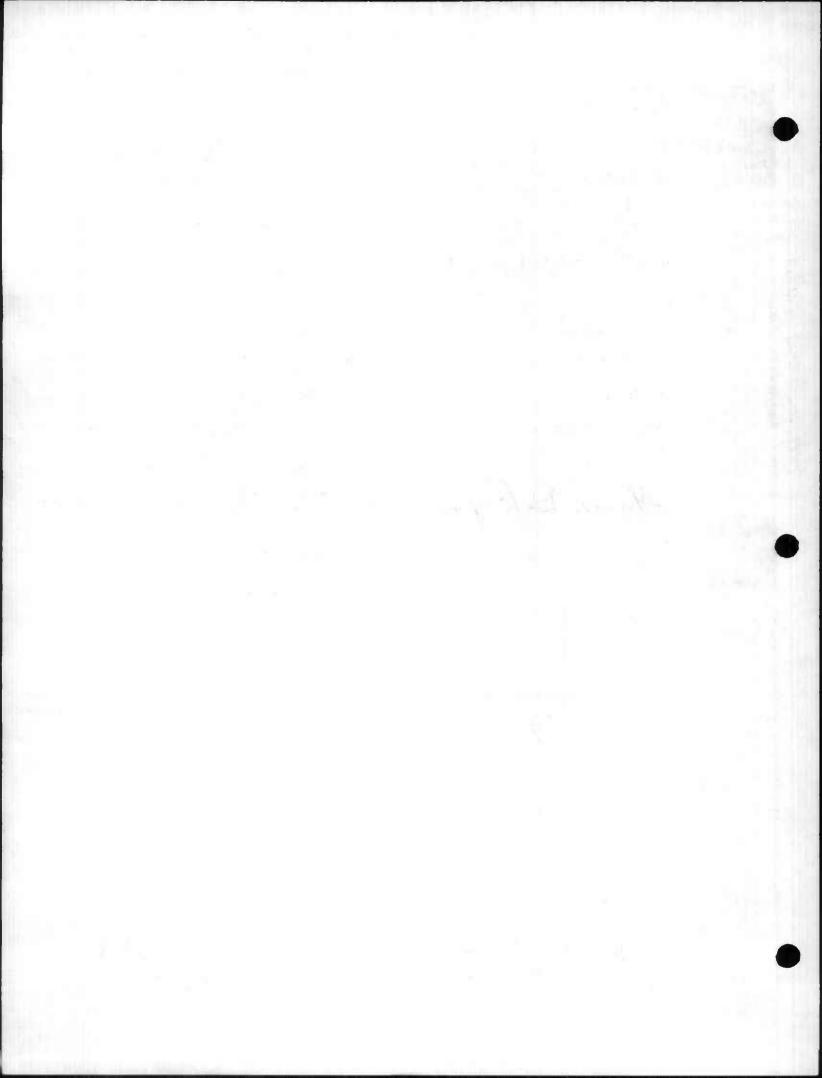
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

m. 0. 90 DAVE, land

State Registrar

31. Dete filed (Month, Dey, Yeer)
APR 02 1998

32. Registrer's Signeture ia savidron-Randall



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month MARCH aymond /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itella laris rercu If Under 24 Hrs. Hours Min. B. Date of Birt (Month, De) If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** MOTEN, KAYMOND Months Days 1**X**M 2□ F 212-32-6660 Usual Residence of Decedent Yrs **Director** 12, 1936 Washington D.C 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examines must be notified as Id. Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 21218 Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 11. Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Delive Maryland Reproduction Center 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Jefferson larjorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Johnson Great nieco 22 No Popk ton Street, 20b. Place of Disposition (Nemb of cemetery, cremetory or other place) Date Baltimore Maryard 21201 20c. Location - City or Town, State 20a. Method of Disposition Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home, PA 23a. Part1. Enter the disaasa, or complications that caused the ceath. Do not antar the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) 9 signed by the a P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by Completed 24a. Was an autopsy performed? 2000 Be 25. Was case referred to medical 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 7 Manner of Deeth Certification: After t 1 Watural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral DI 29a. Certifier Medical (Check only

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

3. Time of Death

10

Birthpiaca (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

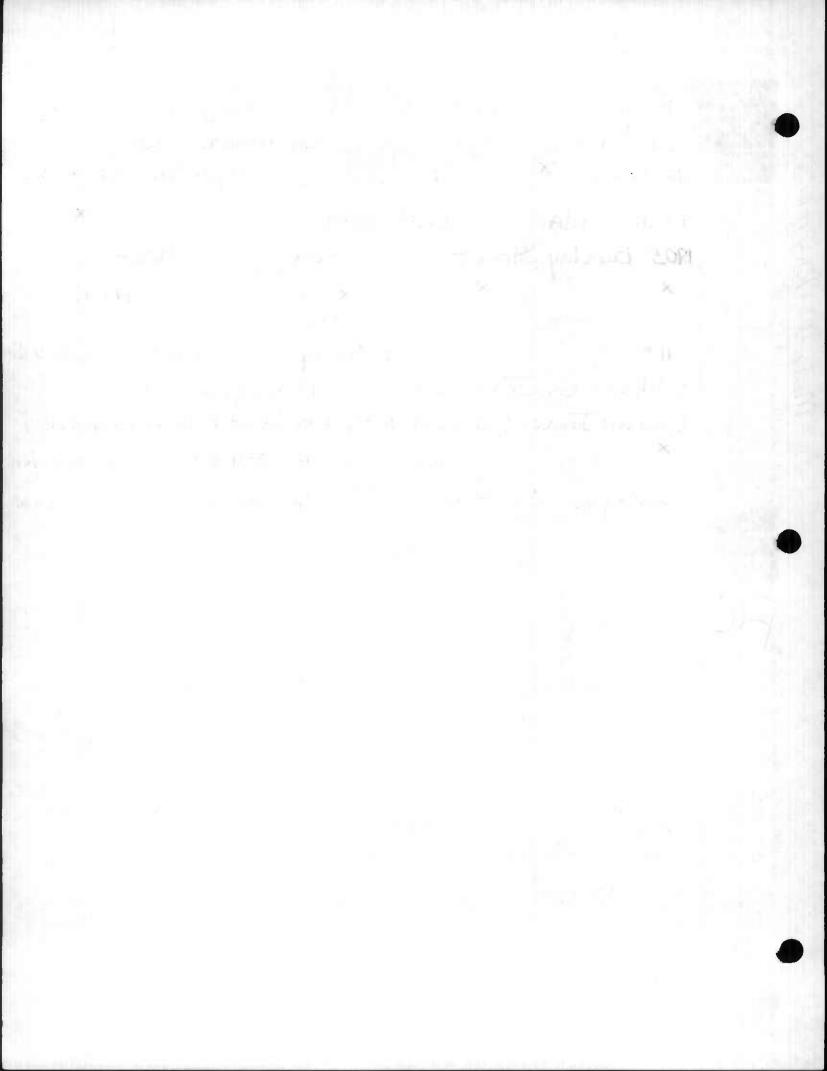
Patrimore, Mary and 2/2/2 rest, Approximate Interval Between Onset and Death unknour 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avallabla prior to completion of cause of death? 1 ☐ Yes 2 ☐ No MARIS 26. Place of Death (Check only one StElli) 5 ☐ Residence 6 Mother (Specify) HOSpic 28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as staled.
2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) Dano MD 040480 MARCH 27, 1998 301912 7672 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) FERRO, MD 21236 32. Registrar's Signature Juna Davidson Mandalle

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

02 1998

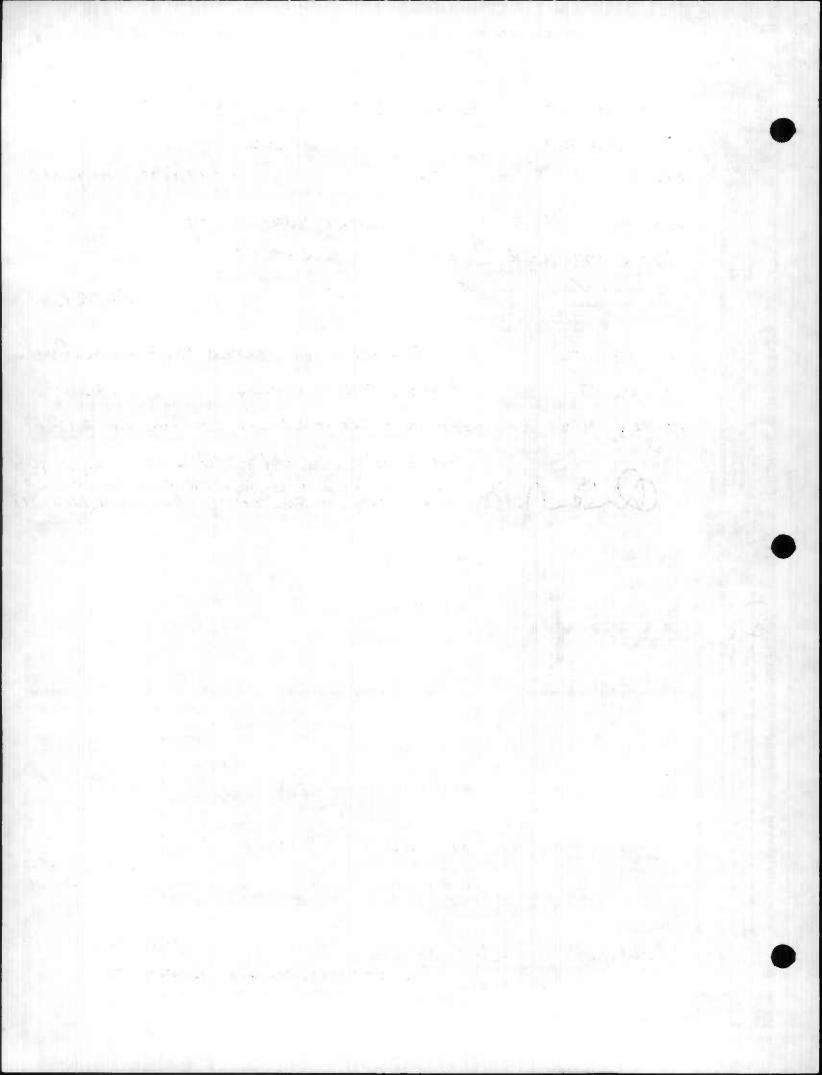


98-1781-510 Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene ROBERT LEON Certificate of Death MACK 1 Decedent's Name /First Middle (ast) 2. Date of Death 3. Time of Death Dey 1998 Year MARCH 31, **Physician** MACK 02:05 AM KOBERT EON /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 3101 SWANN DRIVE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB, 12, 19 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 10 M 20 F Days Hours Min. 49 216-50-1823 Usuel Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? Is marked other than "naturel", or items 23s or 28a-f show traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MARILLAND 10e. Street and Number 10g. Citizen of What Country? BOOKER 1606 OURT USA. Funeral 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter dea Department of Health end Mental Hygiene. Important: If fam 27 is marked other them. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 + HGRANDE ONSTRUCTION WORKER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1606 BOOKER COURT, BALTIHORE, MD. 21217 ce of Disposition (Name of Date 20c. Location - City or Town, State AUDREV MOTHER) MACK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State MT. ZION CEMETERY 4 □ Donation 5 □ Other (Specify) LANSDOWNE, MARYLAND 22. Name and Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory effect, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Hanging Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 687,60 Physiclan/Medical Due to (or as a consequence of): 88 188 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Records, þ 2 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? Inspection page 2 s certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 X Yes 2 □ No To this 28d. Deecribe how Injury occurred
Suspended from tree with uneral 27 Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of injury Certification: 28c. injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town. State) 3101 Swann Drive death. 3-31-98 untrown 2 Accident tha 24 hours after deat Funerel Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 X Suicide filled in by 4 Homlelde Druid Hill Pank Baltimene City, Manyland Hospital 29a. Certifier Medicai completaly 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 31, 1998 OCME 30. Name and address of person who completed cause of death (Hern 23) (Type, Print)

The Penn Street, Baltimore, Maryland 21201 Stephen Flouistrac's Signature 31. Date filed (Month, Dey, Year)

State Registrar

02 1998



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene r Gertificate of Death Item 16a,b per FH Film G758 4-2-98 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MÄRCH 28, 1998 **LEONARD McCARGO** 7:00 AM 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) 4117 ELDERON **AVENUE** BALTIMORE N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 88 Days 1 M 2□F Months Hours Yrs. 214-18-1994 Usual Residence of Decedent June 3,1909 Virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Saltimore md. NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 14. Race - American Indian, Bleck, White, etc. 21215 Hvenue JO. Ider 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1□ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) CHURCH PASTOR Elementary/Secondary (0-12) College (1-4or 5+) argo 5 18. Mother's Name First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) McCARGO JOHN MILLIE BRADLEY 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) BUTLER DAUGHTER 4117 ELDERON AVE., BALTIMORE, MARYLAND 21215 CLARA 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removel from State MARYLAND NATIONAL CEMETERY 4-3-98 LAUREL, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Segrice Licensee JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 100 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE a. CONGESTIVE Due to (or as e consequence of): CARDIO MYOPATH Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1□ Yes 2☑ No 1 Yes 28 No 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner steted.

29c. License number

02

WASHINGTON

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

BLVD

29d. Date signed (Month, Day, Year)

BALTO. MD 21230

Physician /Medical Examiner 68760

Examiner

Physician/Medical

by

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "naturel", or items 23a or 28s-f show treumstic event, the Medical Examinal mast be notified at

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Injury

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is 1 end 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "naturel", or ite

permit. Pages 1 Department of H Important: If iter

Maryland 21215-0020

Baltimore,

Box

P.O.

Division of Vital Records,

Funeral Director

by

Completed

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deeth

980 5 報 page 2 certificate director.

ä Athar To the Mospital or Attending within 24 hours after death. To the Funeral Director: After

Completed 88 To Certification: Ē 30 edical

2 O

29b. Signeture end title of certifier

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

State

1 HOMAS 5 31. Date filed (Month, Dey, Year)

2 Accident

3 Sulcide

29a. Certifier

4 ☐ Homicide

(Check only one)

investigation

6 Could not be determined



MILLER

APR 02 1998 Registrar

700

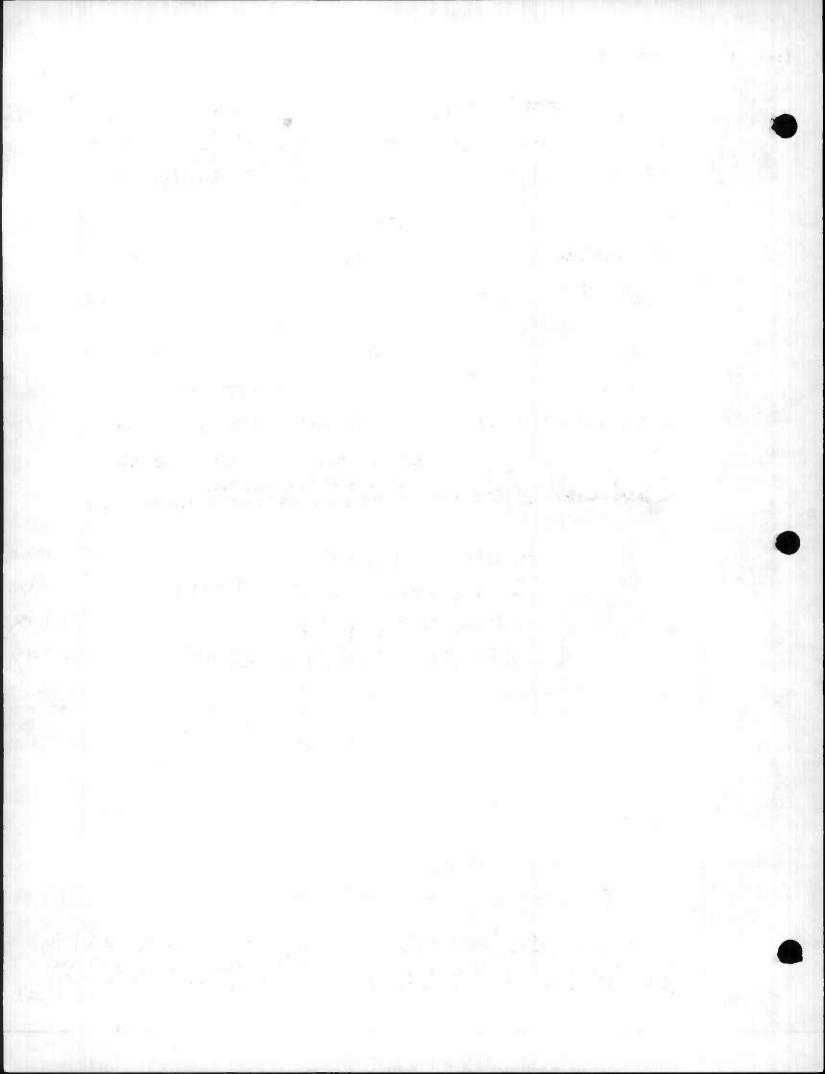
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Western territory TENNIA PRIZER LEMMINERS PHY COLONICA WELLER, MISSISS MARKAMAN SELLES Some Horsem Borney 42 to 12 years to mary male

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Physici /Medi Examir Funeral	al	1. Decedent's Name (First, Middle, Last) ENA 4a. Facility Name (If not institution, give street end num 5. Social Security Number 6. Sex	HOSPI HOSPI	TIAL		MORS	2 27 4c. County	3. Time of Death 5 0 0 of Death 9. Birthplace (State or Foreign
Director		218-01-2964 1□ M 25xF Usual Residence of Decedent 10a. State 10b. County		Yrs. Months Days		8. Date of Bird (Month, De NOV 16,	y, Year) 1919	MARYLAND
with the Maryland as or 28a-f show	Director	MD N/A 10e. Street end Number	,	LTIMORE 10f. Zip Code			10g. Citizen of W	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
er deeth Items 23	by Funeral Di	522 SUNSET ROAD 11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed For 1 Yes, Given Year or Divorced	2 💢 No 9	21223 13. Was Decedent of If Yes, specify Cub 1 □ Yes 2 ☑ No	Hispanic Orlgin? (Spenar, Mexicen, Puerto		U.S	S . A . - American Indian, k, White, etc.
2121 d within giene.	Be Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) 7TH GRADE 17. Father'a Name (First, Middle, Last)	-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire HOMEMAKER	during most of worki			MEMAKING
Aarylar 2 should be and Menta is marked raumatic ev	ToB	JOHN BROOKS 19e. Informent's Name/Relationship (Type, Print)		Mailing Address (Stree	t and Number or Rura		er, City or Town,	Stete, Zip Code)
of Heali		WILLIAM G. MUIR (HUSBAN) 20a. Method of Disposition 1 Dispurial 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	20b. Place of cemeter	22 SUNSET R Disposition (Neme of y, cremetory or other ple AWN CEMETER	ece)	ITMORE, Date /31/98		City or Town, Stete
Baltim permit. Pag Depertment important: h any Injury o once.		21. Surroure of Fundrei Service Licensee	annon	22. Name and Addre HUBBARD FU 4107 WILKE	INERAL HOMENS AVENUE	-BALTIM	ORE, MD	21229
Physician /Medical Examiner		Immediate Ceuse (Final disease) are condition that cause on early conditions that cause on early cause on early cause on early cause or cause on early cause or condition resulting in death)	ach line.		ing, such as cerdiac (or respiretory ei	rest,	Approximate interval Between Onset and Deeth
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760, te be ex ysician	Ical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last	Due to (or as a c	ON TI	SPILLI	4TIO	V	24 DA
ords, P.O. Box 68 requires that the death certificateen signed by the attending phy hould be detached for use as the	by Physician/Med	Part II. Other significant conditions contributing to de	ath but not resulting in			23b. Dld 1	obacco uee con	tributa to the cause of death?
	Completed by P					24a. Was	en eutopsy rmed?	24b. Were autopsy findings available prior to completion of ceuse of deeth?
f Vital Recysician: The law scentificate hes to director, page 2 s	Be	25. Was cese referred to medicei examiner?			26. Place of Death	1 Check only o		1 Yes 2 No
On of sting Phys After this funeral di	cation: To	27. Menger of Death 1 Maturel 5 Pending (Monti 2 Accident investigation	n, Day Year) Ir	Time of njury M 1	ry at ork?] Yes 2 □ No	28d. Describe I	dence 8 Othe	ed
Division To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral	edical Certification:	4 Homicide determined 208. Place buildin 29a. Certifier 1 Certifying Physician: To the	g, etc. (Specify) pest of my knowledge.	rm, street, factory, office	ime, date end plece,	City or Tov	vn, Stete) ceuse(s) and mar	er or Rural Route Number,
To the Ho within 24 t To the Fu completel	Medic	(Check only one) 2 Medical Examiner: On the be and mann 29b. Signature end title of certifier 30 Name and address of person who completed cause	sis of exeminetion end	29c. Licen	se number	ed at the time,	29d. Date signed	(Month, Dey, Yeer)
Sta Registr		BELLNARDO VI. G	Davidson-Ru	5 R	3000	W. P.	BALTIN	TOS PITAL WOVE ST.

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 19a Per FH Film G-758 4-2-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HILDA MOFSOWITZ MARCH 26 1998 7: 57 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL CENTER NORTHWEST RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F. Months Days 216-07-3772 Director OCT.31,1913 MARYLAND Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Matical Examinar must be notified at 10d. Inside City Limits MD N/A BALTIMORE 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 FORDS LA., APT. 608 Funeral 21215 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes ⊆ 2 M No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after in and Mental Hygiene.
Is marked other than "natural", or itse 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify à WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SALESPERSON SHOES 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) LOUIS MOFSOWITZ YETTA GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sl Department of Health an Important: If Itam 27 is n BALTIMORE, MD 21208
Date 20c. Location - City or Town, Stete CARL KLUPT (NEPHEW) other 8218 ARROWHEAD RD. Baltimore, 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or AITZ CHAIM 3/29/98 BALTIMORE, MD 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. any 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 cations that paged the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the disease, or comp **Physician** /Medical Immediata Cause (Final CONGESTIVE HEART FAILURE 40010 disaasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical physic Due to (or as a consequence of): 2 = P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed 1 Yes 20 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Yeer) funeral 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of 28c. Injury at Work? Certification: After t is after death.

I Director: After to in by the funers Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 Suicide 28e. Placa of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Dertifying Phyelclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signatura and titla of

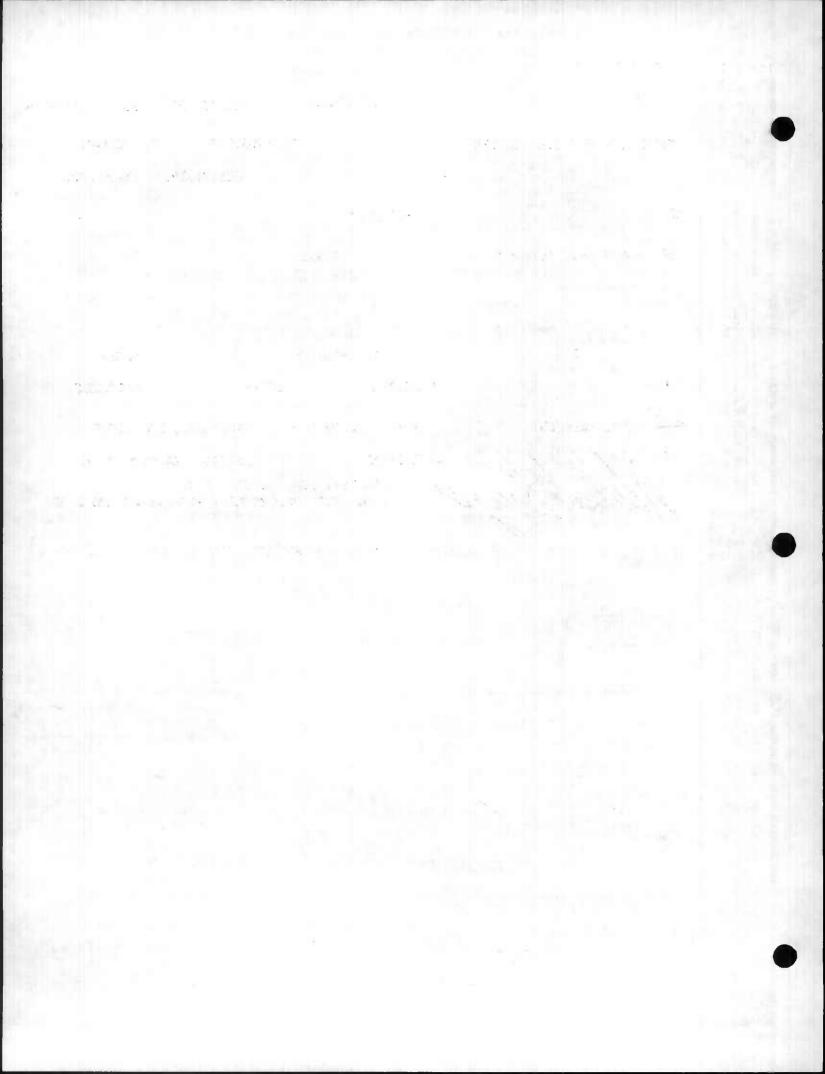
empleted cause of deeth (Item 23a) (Type, Print)

M

ER1102

12 Registrar's Signature

State Registrar 30. Name and address of person,



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar 98 **Physician** Raymond Merchant March 9:45pm · /Medical 4b City Town or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Stella Maris At Mercy Hospice Baltimore NA If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) If Undar 1 Yaar 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days XXM 2DF 70 212-24-8217 Yrs. **Director** 07-25-27 VA Usual Rasidanca of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits rithan "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1□Yas 2□No Director MD. NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? #104 21213 USA 1300 East Lanvale Street Apt. Funerai death 12. Was Decedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, Black, Whita, atc. 12 should be filed within 72 hours effer. I and Mental Hygiene. Yas 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Black þ 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 12th Grade Glidden Paint Co. Laborer other treumatic event. 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) William Merchant Delah Brown 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Code) 21206 19e. Informent's Name/Ralationship (Type, Print) permit. Pages 1 and 2 sh Department of Haaith and Important: If Item 27 Is m 5211 Moravia Road Apt. "C" Baltimore, Md. Ronald J. Merchant, Sr. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod ol Disposition 20c. Location - City or Town, Stata Md. ò 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval Irom Stata Garrison Forest VA Cem. 04-01-98 Owings Mills, injury 4 □ Donation 5 □ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Funarai Sarvice Licensee any it Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. tarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical ESOPHAGEAL CANCER 2 years **Examiner** Dua to (or as a consaguança ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Diseasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consaguance of): certificata be edical Dua to (or as a consaguance of): 50 Physician/M 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Wara autopsy lindings available prior to completion of ceuse ol death? 24a. Was an autopsy performed? Completed page 2 has 1 Yas 2 No 1 Yas 2 No certificate 25. Was casa ralarrad to medical axaminar? director Be 26. Pleca ol Death (Check only ona) STELLA MARIS Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2 No To this MERCY 28a. Data ol Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 27. Mannar of Death 28c. Injury at Work? Certification: After 5 Pending invastigation Attending 1. Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident aftar deat 6 Could not be datamined 3 ☐ Suicida 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, streat, factory, office building, atc. (Specify) 4 Homicida 6 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated. 29a. Certifian edicai completaly (Check only one) To the To the To the I 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian Jarron 040 480 7672 Belgir Ra 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

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32. Ragistrar's Signatura

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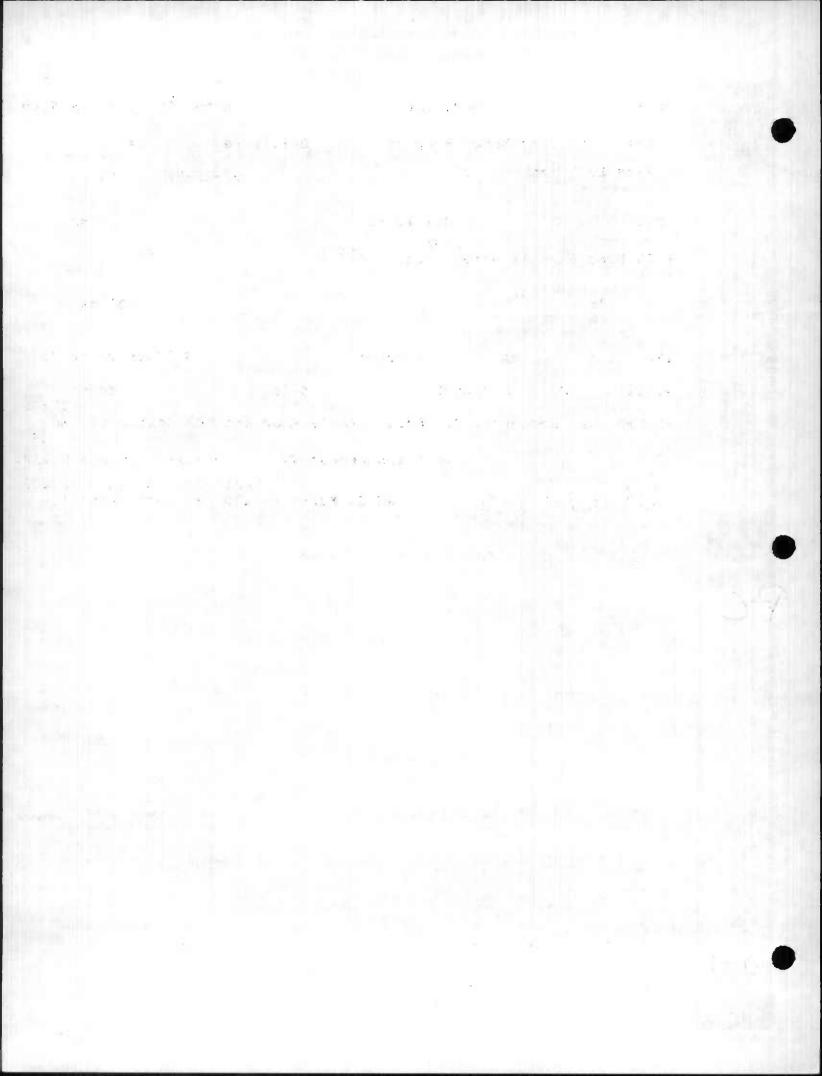
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31. Data lilad (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

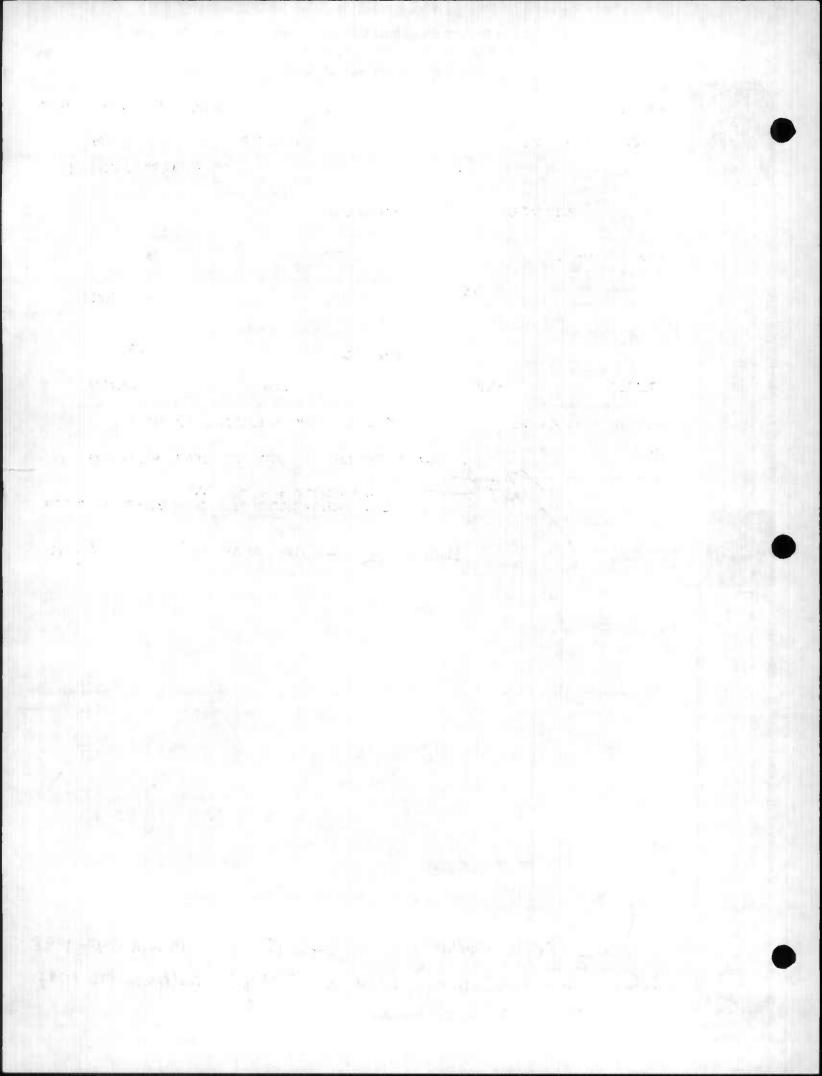
Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 1998 5:48AM MASH MARCH NATHAN /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** 3709 BRETON WAY BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
OCT. Pay, Year 920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1₽M 2□F Days Hours 77 MARYLAND Yrs. 213-14-3731 Director Usual Residence of Decedant the Merylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at BALTIMORE BALTIMORE MD 1 Yas 2 Tho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3709 BRETON WAY 21208 USA Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Bleck, White, atc. 12 should be filed within 72 hours after on the should hygiene.
Is marked other than "natural" or have 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 💢 🏋 o Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MEAT PRESIDENT 9 17. Father'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH MASH TDA BISKOR Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st Department of Health end Important: If Item 27 is n any injury or other treun page. PAULINE MASH / WIFE 3709 BRETON WAY; BALTIMORE, MD 21208 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Nuriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) SHAAREI TFILOH MAR. 29, 1998 BALTIMORE, MD 21. Signature of Funerel Service Licania 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208
Approximate on each line. 23a. Part1. Enter the disease, or co shock, or heart failure. List of Approximete fntarval Batween Onset end Death **Physician** /Medical Immediate Cause (Final MON AMAIL CELL Lyears LUNG Langer diseese or condition resulting in death) **Examiner** Due to (or es a consequence of): Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events resulting In death) Lest Due to (or es e consequence of): physician Physician/Medical Due to (or es e consequence of): the BSF signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy peen hes 1 ☐ Yes 2 No 1 Yes 2 No Attending Physician: funeral director 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 1 Naturel 5 Pending deeth. 1 ☐ Yes 2 ☐ No 2 Accident after deeth 6 Could not be datermined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 8 24 hours 29a. Certifier Medical 1 🖰 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. (Check on one) within 2 To the 29b. Signeture 29c. License number 29d. Date signed (Month, Day, Year) MARCH 27th 1998 Mopho 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

Oke. II. Journ's Hoffin Okoron (201)

31. Data filed (Month, Day, Year)

32. Registrar's Signatura bas N Work St Baltimore MO 21287 Sole II Jan 31. Data filed (Month, Day, Year) Certar, Registrar's Signatura State APR 02 1998 wie Daydoon-Randall Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day GRACE MARIE METLE 29, MARCH 1998 7:25 A.M. 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death HAMMONDS LANE NURSING HOME N/A BALTIMORE 8. Date of Birth (Month, Dey, Year) 5 Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign
Country) Days 1 M 20 F Months 212-12-6723 Yrs. 77 BALTIMORE, MD NOV 18, 1920 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 2741 YARNALL ROAD 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 YR HOMEMAKING HOMEMAKER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) NATHAN L. ADAMS GRACE O. CLARK 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) 2741 YARNALL ROAD - BALTIMORE, MD JUANITA L. SCALLIO (DAUGHTER) 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State CRESTLAWN CEMETERY 4/1/98 BALTIMORE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION HOUR disease or condition resulting in death) Due to (or as a consequence of): AMERIOSCUEROTIC CARDIOVASCULAR Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): DUSGASE Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Tes 2 No 3 Probably 4 → Unknown DEMENTIA 24b. Were eutopsy findings aveilable prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 TYes 2 TNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 Yes 2 Accident 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

> 29c. License number 121776

29d. Date signed (Month, Day, Year)

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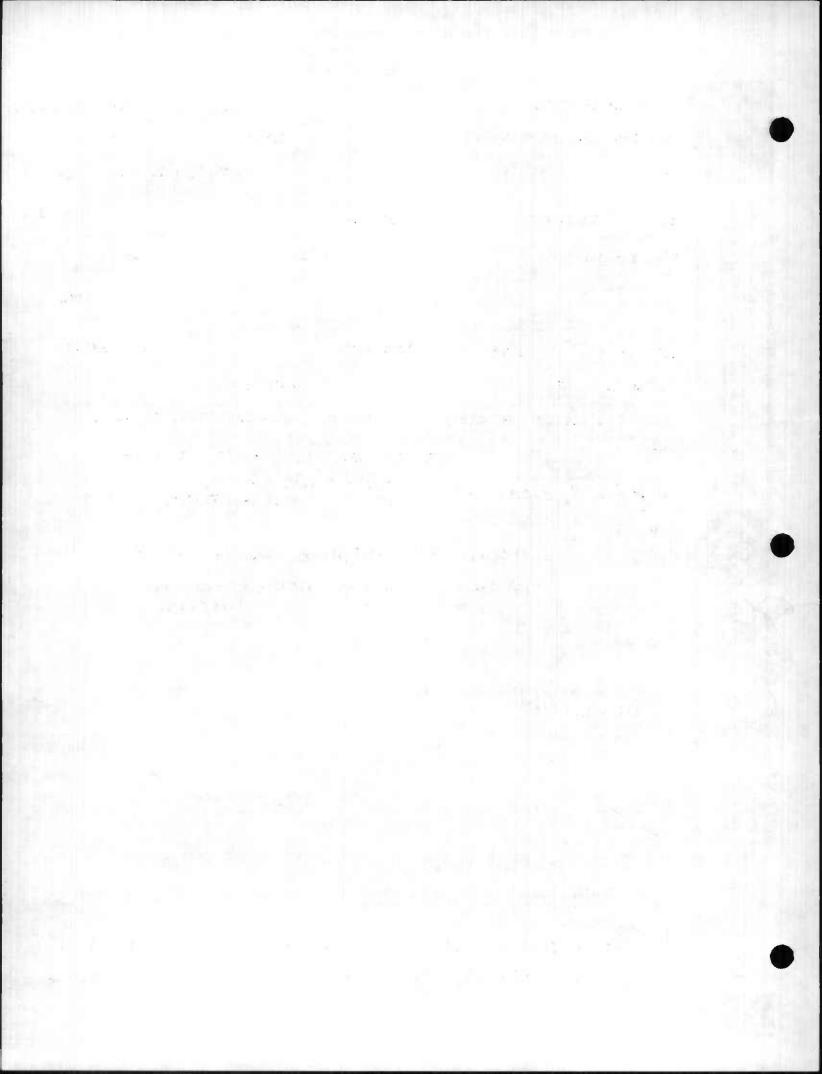
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31. Date filed (Month, Dey, Year) APR 0 2 1998

29b. Signature and title of certifier

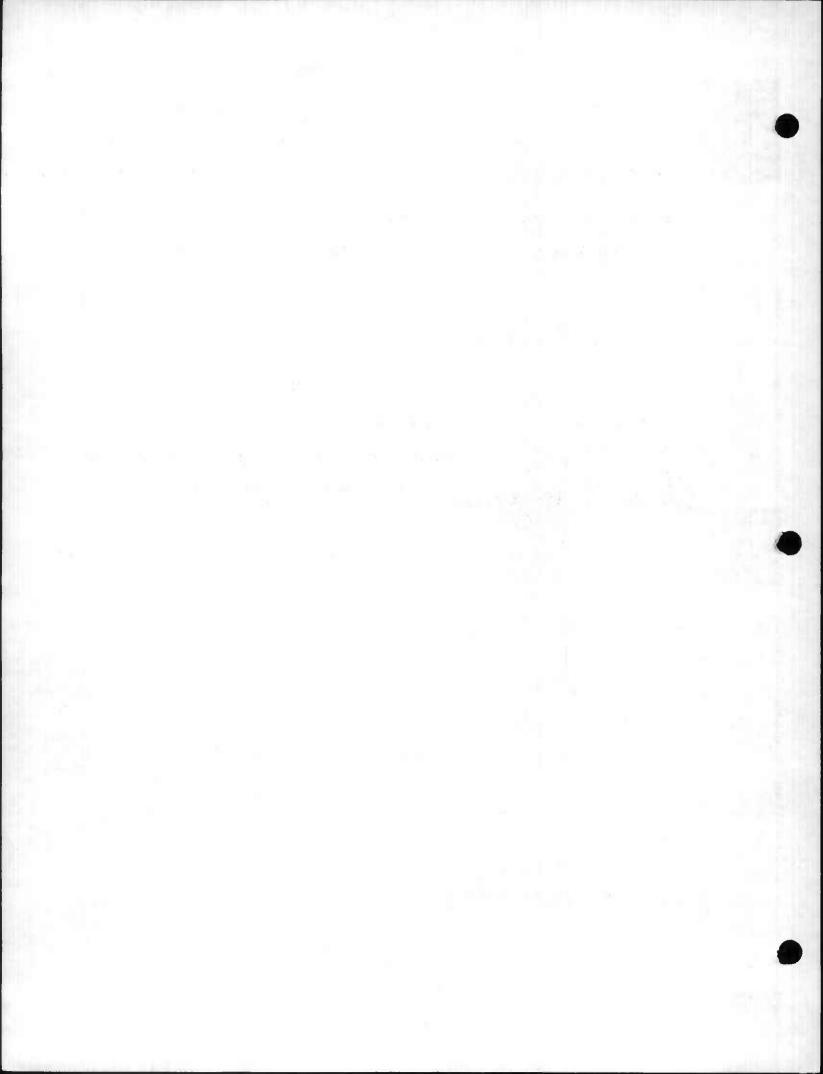
Weldy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





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	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	l,S. 13.	Was Decedent of It Yes, specify Cub	Hispenic Origin? (Spen, Mexicen, Puerto	pecify Yes or No Rican, etc.)		e - America ck, White, e	
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7 is m treum		19e. Informent's Name/Relationship (7) MR. JAMES NAGLE	rpe, Print)		ling Address (Street					Code)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) DARR 30, 1448 MORAN Month **Physician** 1erunica 11370 MARCH /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Carroll County General Hos. Carroll Co. Westminster If Under 24 Hrs. 8. Dete of Birth
Hours | Min. (Month, Dey, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Deys 1 M 2 KF Months 54 Yrs. Director JULY 19, 1943 218-42-0906 New Jersey Usuel Residence of Decedent the Merylend 10d. Inside City Limits 10a. Stete 10c. City. Town or Location 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Carroll Co. Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 182 Baronets Drive 21157 USA deeth Funeral permit. Pages 1 and 2 should be filed within 72 hours after deelt Department of Health and Mental Hygiene. Important: If tem 27 is marked other the any Injury or other trauments. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑No If Yes, Give Year or Detes: 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Stetus 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: white Specify þ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Personnel Director Johns Hopkins University 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Joseph Moran Ellen Ferry 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) William G. Parr - husband 182 Baronets Dr., Westminster, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4/03/98 Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Park 22. Name end Address of Fecility
Gary L. Kaufman Funeral Home @ Meadowridge MP Inc 21. Signeture of Funerel Service Licensee 7250 Washington Blvd., Elkridge, Md. 21075 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner PNEUMONIA Examiner The law requires that the deeth certificate be executed physicien and s the bunal-trens Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Lest of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of deeth? the isigned by the 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Winknown SYSTEMIC LUPUS ENYTHEMATOSU þ 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? STOBRENS SYNDROME 24e. Wes en autopsy Completed peen s page 2 0 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes certificete Physician: 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To this 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menper of Death 28b. Time of 28d. Describe how injury occurred Certification: Drysion or Attending Naturel 5 Pending 1 Tes 2 No 24 hours efter death. Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated. 2 ■ Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. (Check only one) within 2 eq: 29b. Signeture and title of certifier

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State Registrar Lay

31. Dete filed (Month, Dey, Year)

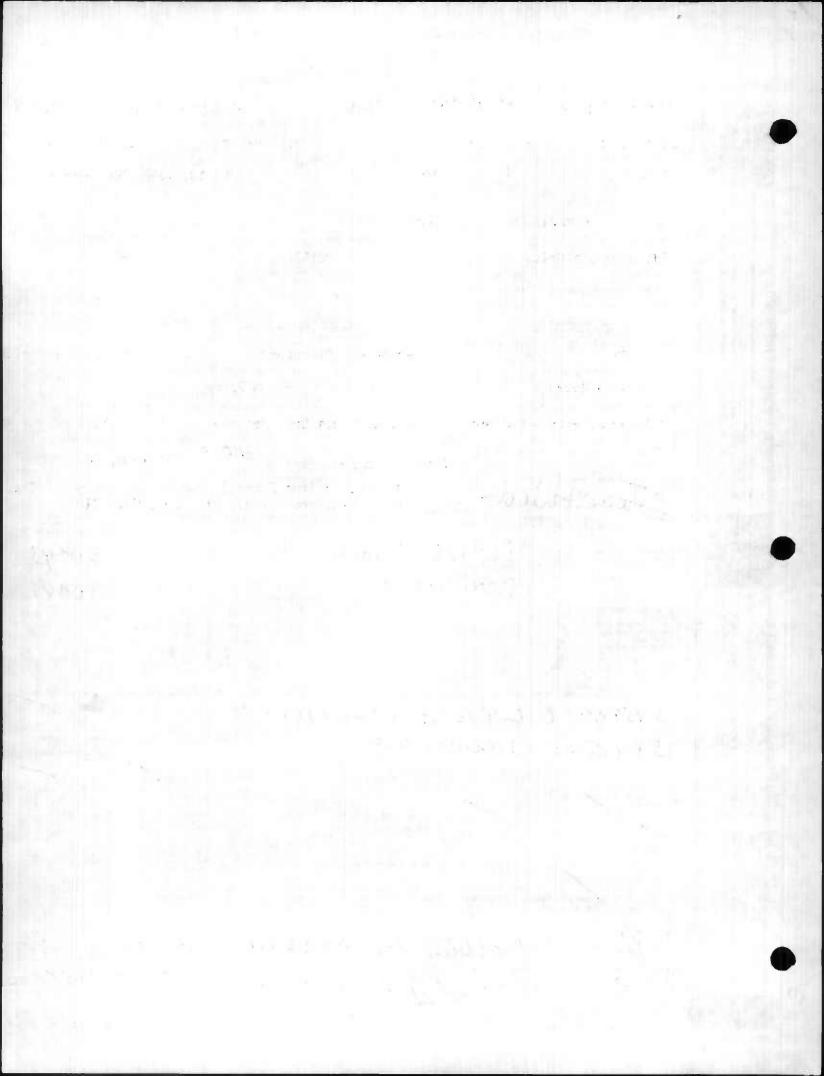
30 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registration

Jelia Davidson

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Data of Death Month **Physician** Koss Kevin 1998 MARCH 10:20 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner BALTIHORE 1425 N. AISQUITH 6. Sex 7. STREET If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 19 M 2□ F Months Days 214-82-7748 Yrs Director MARULAND Usual Residence of Decedent with the Maryland 10a State 10h. Count 10c. City, Town or Location 10d. Inside City Limits 19 Yes 2 No BALTIMORE Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? 7 is marked other than "natural", or flams 23s or traumatic avent, the Medical Examinar must be 21200 12. Was Decedent Evar in U,S. Armed Forcas? 1425 USA. permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23s any injury or other traumatic avent, the Medical Exercise. Funeral 14. Race - Amaricen Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 1 Yas 2 No Spacify: altimore, Maryland 21215-0020 Specify: BLACK p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16h Kind of Rusinass/Industry Etementary/Secondary (0-12) College (1-4or 5+) WHOLESALE COMPANY 12 TH GRADE CLERK STOCK 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be ROSS MATTHEWS MARTHA ISAAC 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1425 N. AISQUITH STREET BALTIHORE, 40, 21202 ce of Disposition (Nama of Date 20c. Location - City or Town, State MARTHA MCAFEE LMOTHER 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State VOSHELL CEMETERY 3-30-98 BALTIMORE, MD 4 Donation 5 Other (Spacify) 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errast,

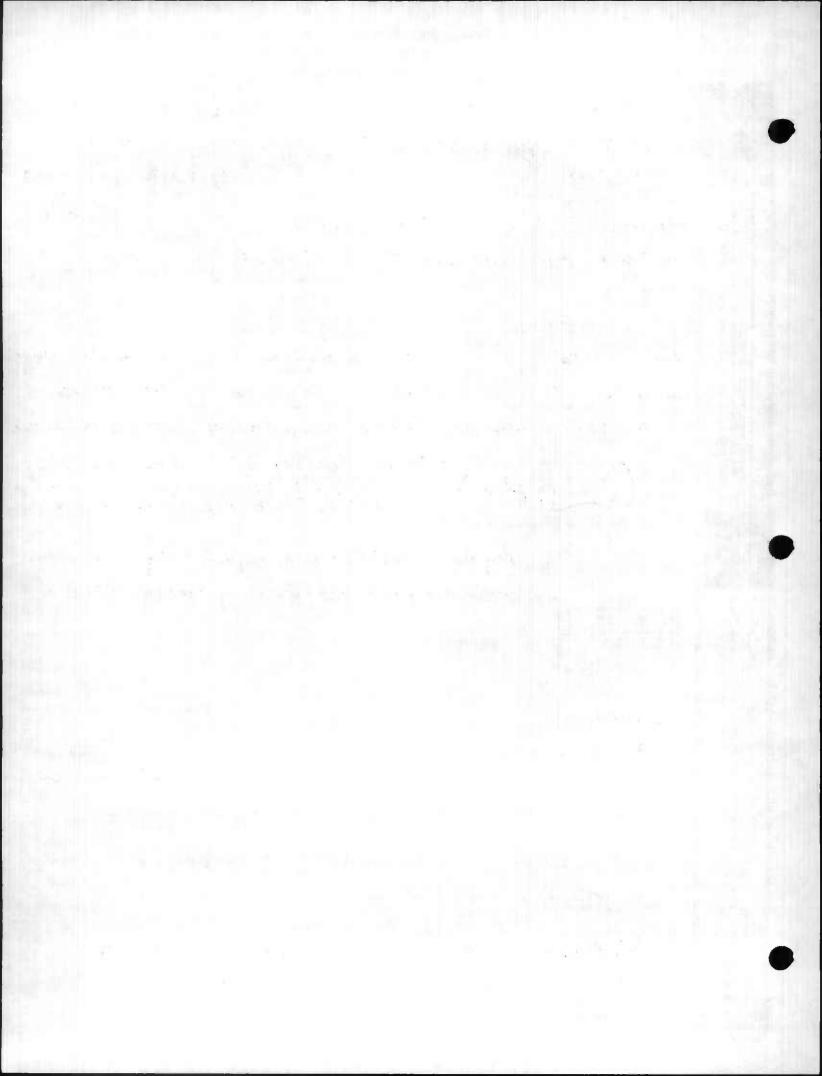
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Approximate of Funeral Service Licensee 22. Name and Addrass of Facility **Physician** Immediate Cause (Final disaasa or condition rasulting in daath) /Medical Progressive multifocal leukoencepholopathy Examiner Advanced acquired immunodelicency Syndrome Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; Due to (or as a consequenca of) signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown De hydration þ 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed Westing Syndrome s certificate has I director, page 2 s 1 Yas 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director; After this certificaletaly filled in by the funeral director. 25. Was cese rafarred to medical examiner? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 □Other (Specify) 1□ Yas 2□ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiar 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completaly fi edical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) MD. 050707 Karch 28, 1998 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) JA Cecil HD Johns Hopkins Hospital Baltmore Mayland

32 Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) APR 02 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Counth 2 Date of Death Month ROGERS MARCH 3:17 DM 1998 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SECOURS BALTIHORE HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex 9. Birthplace (State or Foreign Country) 213-34-8268 1 M 2 F Months Days 60 37 SOUTH CAROLINA Yrs Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND 10e. Street and Number 10s. Citizen of What Country? 602 ARLINGTON AVE USA. 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 21 No Specify: 3 Widowed 4 □ Divorced Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CASHIER 12 +H GRADE LEXINGTON MARKET 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) CHAVIS GEORGE IOA 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2814 ROGERS (ELLICOTT DR, WAY BALTIHORE, MD. 21216 NANCY DAUGHTER) 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date / 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State KING MEMORIAL PARKH-3-98 WOODLAWN, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P. A. 2140 N. FULTON AVE., BALTIHORE, MD. 21217 audithe death. Do not enter the mode of dying, such as cardlac or respiratory errest, Approximate 21. Signature of Funeral Service Licensee rarion 23e. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown A Syes 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 2 No 1 Yes 1 Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medicai

Examiner

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Director

28a-f show

Items 23s

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traumatic event, the Medical Examiner must be notified at

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Baltimore, Maryland

Box 6876 The law requires that the death Records, P.O. signed by the a Division of Vital

Examiner Certification:

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To the Hospital o within 24 hours af To the Funeral D completely filled i Medicai State

Physician/Medicai

2 Accident 3 Sulcide 4 Homicide 29a, Certifier

29b. Signature and title of certifie

1 Yes

27 Manper of Death

(Check only one)

Natural

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Dey Year)

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30 DOA

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

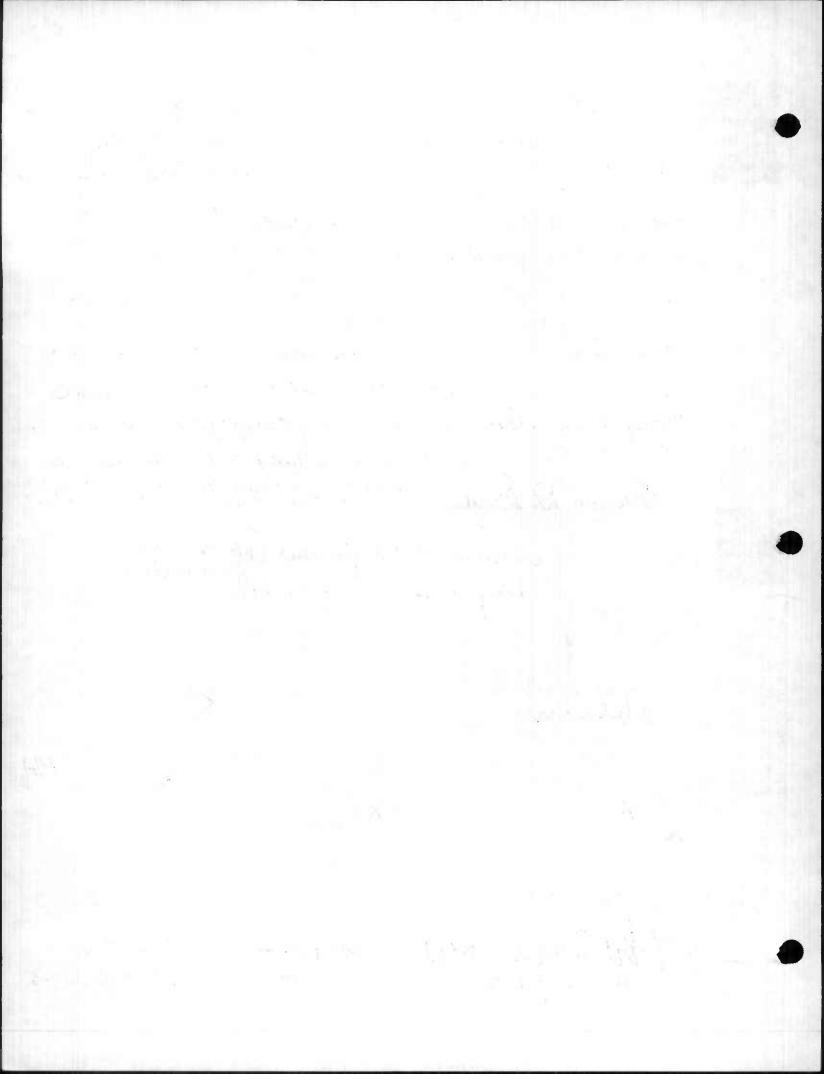
Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

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eted cause of death (Item 23a) (Type, Print) 2000 H.M. Tea MD

31. Date filed (Month, Day, Year) 1998 32. Registrar's Signature Pandage

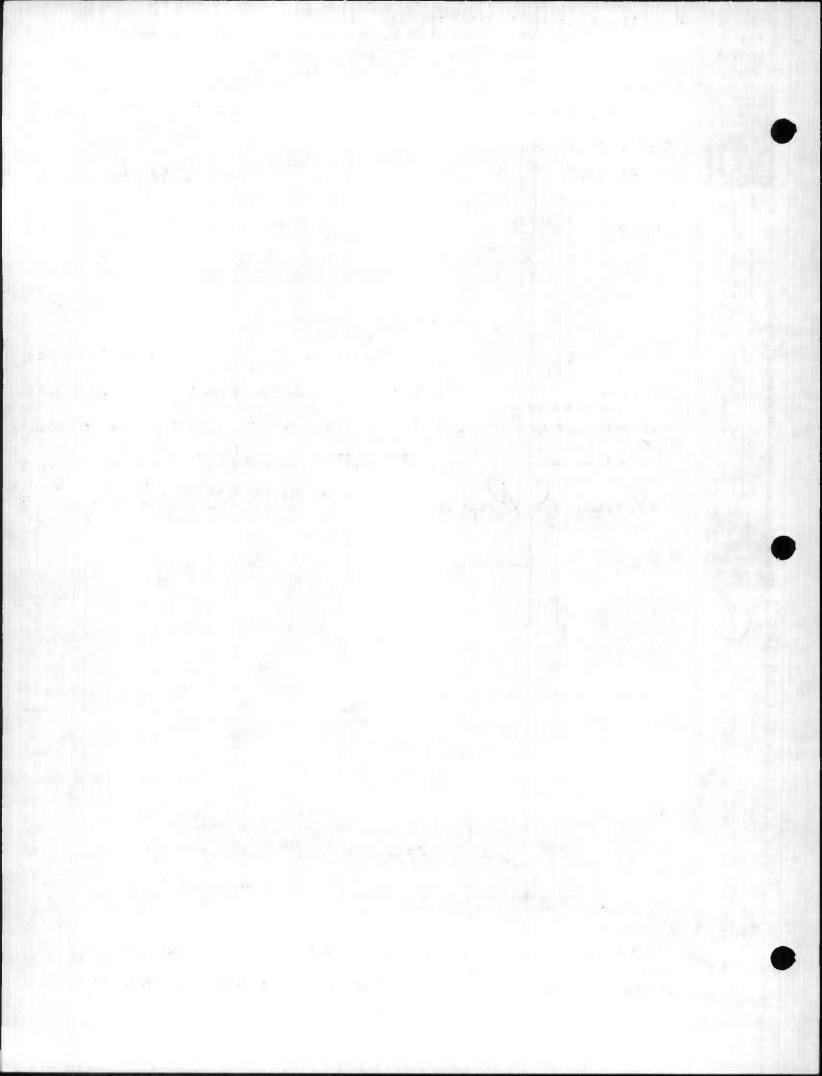


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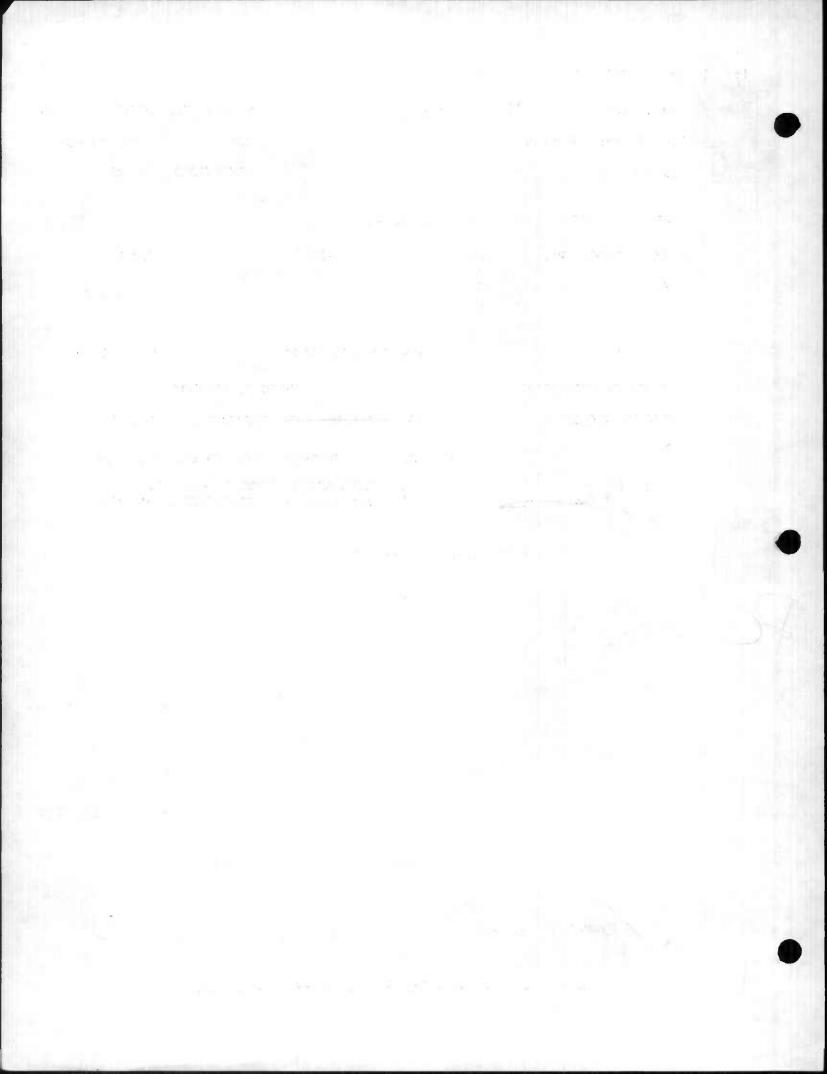
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APR 02 1998



Amend: 19b Per FH Film G-758 4-10-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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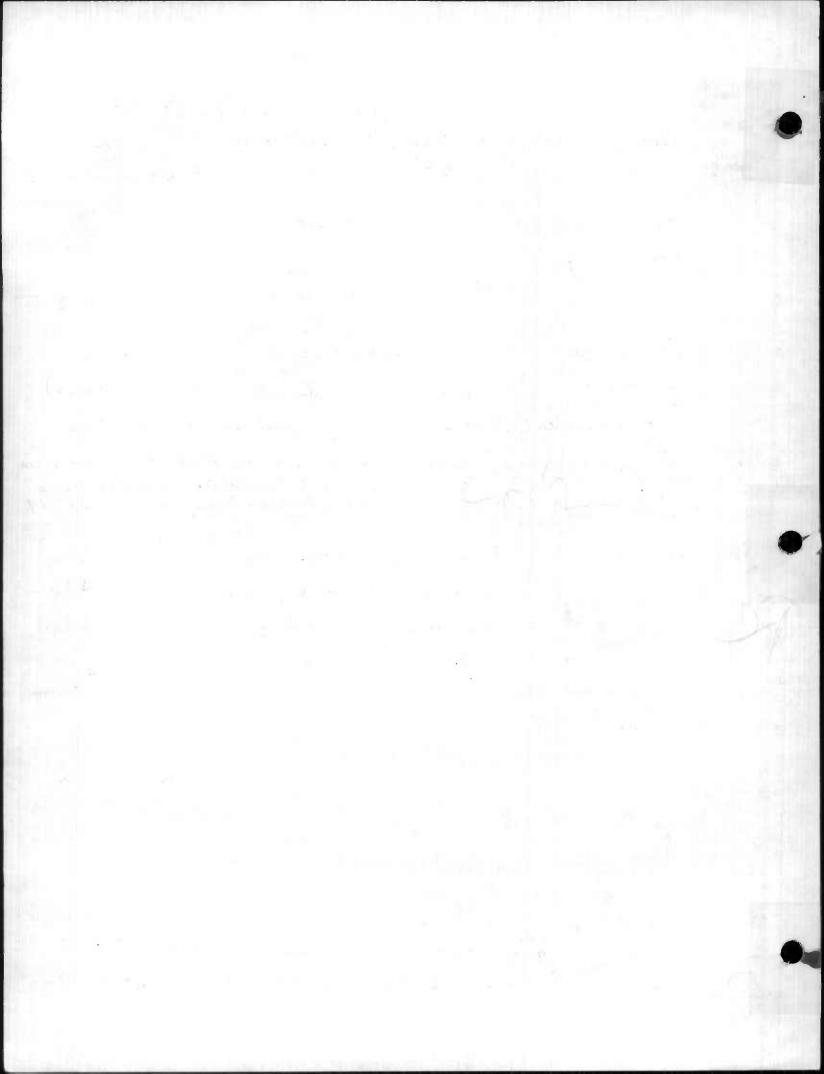


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month tenhenson March 2010 erromca /Medical 4a. Facility Name (If not institution, giva street end number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Hopkins Hospita Battimore Johns NIA last bin If Undar 24 Hrs. 8. Date of Birth (Month, Dev.) HAV 28, 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1 M 20 F Yrs Director NIA JAMACIA, WI Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than the many Injury or other traumatic event, IIIa Medical Examine must be notified at any Injury or other traumatic event, IIIa Medical Examine must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No ROZ RERMUDA Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? WB'S WAV USA, Funeral 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 11. Marital Status 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK 12 +HGRADE SALES UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) SIEMON AMPBEL (MN-UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) OWEN STEPHENSEN WB'S WAY, OCEAN VIEW WEST BERAUGA CROZ f Disposition (Name of Local Date 200. Location - City or Town, Stete (HUSBAND 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burlai 2 ☐ Cremation 3 ☐ Removal from State PEMBROKE PARKISH CEMETERY 4-3-98 PEMBROKE PARRISH BERMUDA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie 22. Nama and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTO, Mp. 21217 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 4 days Examiner intracrania Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): barachnoid Records, P.O. Box 6826 Physician/Medical Due to (or as a consequenca of): Intracranial years ancur ysm Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2⊠ No 3 ☐ Probabty 4 ☐ Unknown Hypertension þ 8 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? Be Completed **58080** 1 Yes 2 No Division of Vital 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) ă after A 4 Homicide To the Hospital o Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) March 27, 1998 RES-000 30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore MD. 2/287 lverman Isaac

32. Registrar's Signature
Fund Davidson Fundall

State Registrar 31. Date filed (Month, Day, Year) APR 02 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** Month 29, 1998 March /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Under 24 Hrs. R Date of Block Richie Joseph 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1**X**M 2□ F Days Yrs. Director Dec. 01, 1953 N laryland the Maryland 10e. Stete 10b. County 10c. City, Town or Location man be notified at 10d. Inside City Limits 1XYes 2□No Director ltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours efter deeth with 21 21 Funeral 1516 SOY Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No It Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American I Bleck, White, etc. 11. Maritel Stetus Pages 1 end 2 should be filed within 72 hours efter d nent of Health and Mentel Hygiane. Intel If Ham 27 le marked other than "natural", or Item IVy or other traumatic evant, me Medical Experime 1 ☐ Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) hef 12 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Romina ber Speights 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) peights (wife) 1516 N. Yays 200. Place of Disposition (Name of camelery, cremetory or other place) Baltimore, Maryland 2121/ 20c. Location - City of Town, State 20e. Method of Disposition Date 1 Buriel 2 ☐ Cremetion 3 ☐ Removei from State permit. Page Depertment of Important: If any Injury or Ar butus Memorial Park 4-3-98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 23. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Funeral Home, PA. 21. Signeture of Funeral Home, PA. 21. Signeture of Funeral Home, PA. 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Funeral Home, PA. 26. Part 1. Enter the disease, or complications that cause the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, 23. Approximate Approximete Intervel Between Onset end Death **Physician** GASTRIC CARCINOMA 5 MONTHS /Medical Immediete Ceuse (Finei disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot): P.O. Box 68760. Physician/Medical tha Due to (or es e consequence of): been signed by the ettandin should be detached for use Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy tindings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes en autopsy performed? pege 2 certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifica 25. Wes case reterred to medical exeminer? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Special DSPICE Certification: To 2 No 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) filled in by 4 | Homicide

To the Hospital within 24 hours a To the Funeral C completely filled

Division of Vital

State Registrar

Medicai

29e. Certifier

30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 101 NREADST SUITE 719 BALTMORE 21261 MACGIBBON

JOHN B MACKIBBON MD

31. Dete filed (Month, Day, Year) APR 02 1998

29b. Signeture and title of certifier

MD /o/ h The Davidson Randalle

may worth

12 Contitying Presiden: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth **Physician** Month 20 B SuhhIVAN CONA /Am 03 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Daeth 4c. County of Deeth **Examiner** Lutheran Retirement Baltimore If Undar 24 Hrs. 8, Date of Bir Hugs boro altimore 7. Aga (In yrs. lest birthday) 92 Yrs. 9. Birthplace (Stete or Foreign **Funeral** Days Hours 1□M 2 F Feb-20 1906 S South Carolina 214-40-5546 Usuel Residence of Decedent Director 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Saltimore imore 10e. Street and Number 10g. Citizen of Whet Country? 6811 Road Funeral Race - American Indian, Bleck, White, etc. 11. Marital Status Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 No If Yas, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Spacify only highest greda completed) 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry College (1-40r 5+) B.S. Degree Elamantery/Secondery (0-12) Baltimore City Roblic Schools eacher 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middla, Malden Surneme) Be rinson huella ee oung 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City ox Town, Stete, Zlo Coda) orithan Road Baltimore Maryland 200. Location City or Town, State livan (son) 3203 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 1 Buriel 2 Cremation 4 Donetion 5 Other (5 3 Removel from State Baltimore National Baltimore, Maryland 5 Other (Specify) 21. Signeture of Fundral Service Licensee 22. Name and Address of Facility Joseph H. Drown Jr. Funeral Home, PA. 23a. Pert1. Enter the disease, or complications that causad tha deeth. Do not antar the mode of dying, such as cardiac or respiratory errast, Approximate Approximate Approximete Interval Between Onset end Death **Physician** /Medicai Immediete Ceusa (Final disaasa or condition resulting in deeth) Examiner Physician/Medical Examiner (A)zheimers demention Sequantially list conditions, if eny, leeding to immediate ceusa. Entar Underlying Cause (Disease or Injury that Initiated events rasulting in death) Lest Due to (or es e consequence of) COPD Due to (or es e consaquance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 7 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveileble prior to completion of causa of deeth? Completed 24a. Was an autopsy 1 Yes 2 18 No 1 ☐ Yas 2 ☐ No Be 25. Wes case refarred to medical 28. Placa of Beath (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Lo 2 No 27. Manner of Deeth 28b. Tima of 28d. Dascribe how Injury occurred Data of Injury (Month, Dev Year) 28c. Injury et Work? 5 Pending Investigation 1 Netural 2 Accidant

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permit. Peges 1 and 2 should be filed within 72 hours eft Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural; or

Baltimore, Maryland 21215-0020

Medical

filled in by the funeral efter death To the Hospital of within 24 hours of To the Funeral Completely filled

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3 ☐ Suicide 4 Homicide

6 Could not be determined

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28f. Location (Straet end Number or Rural Route Number, City or Town, Stete)

1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner stated. 29b. Signature end title of certifier

29c. License number

29d. Data signed (Month, Dey, Year) 26,1998

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30. Neme end eddress d person who completed cause of deeth (Item 23e) (Type, Print)

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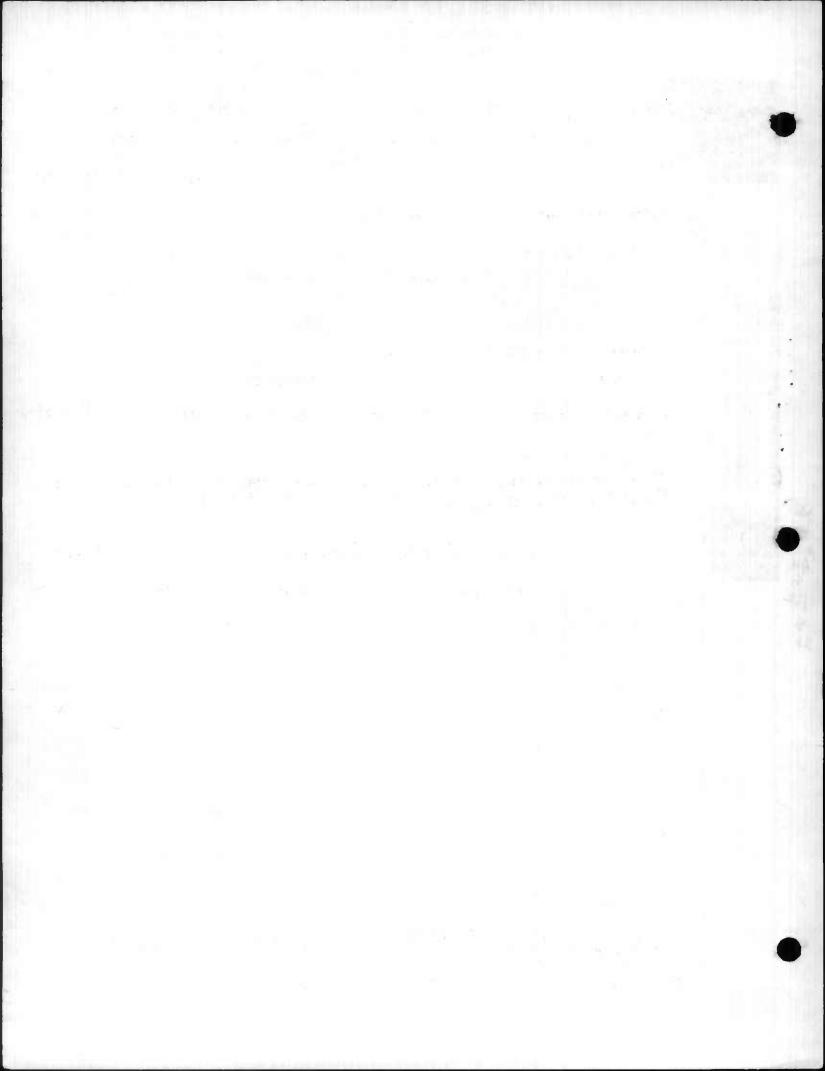
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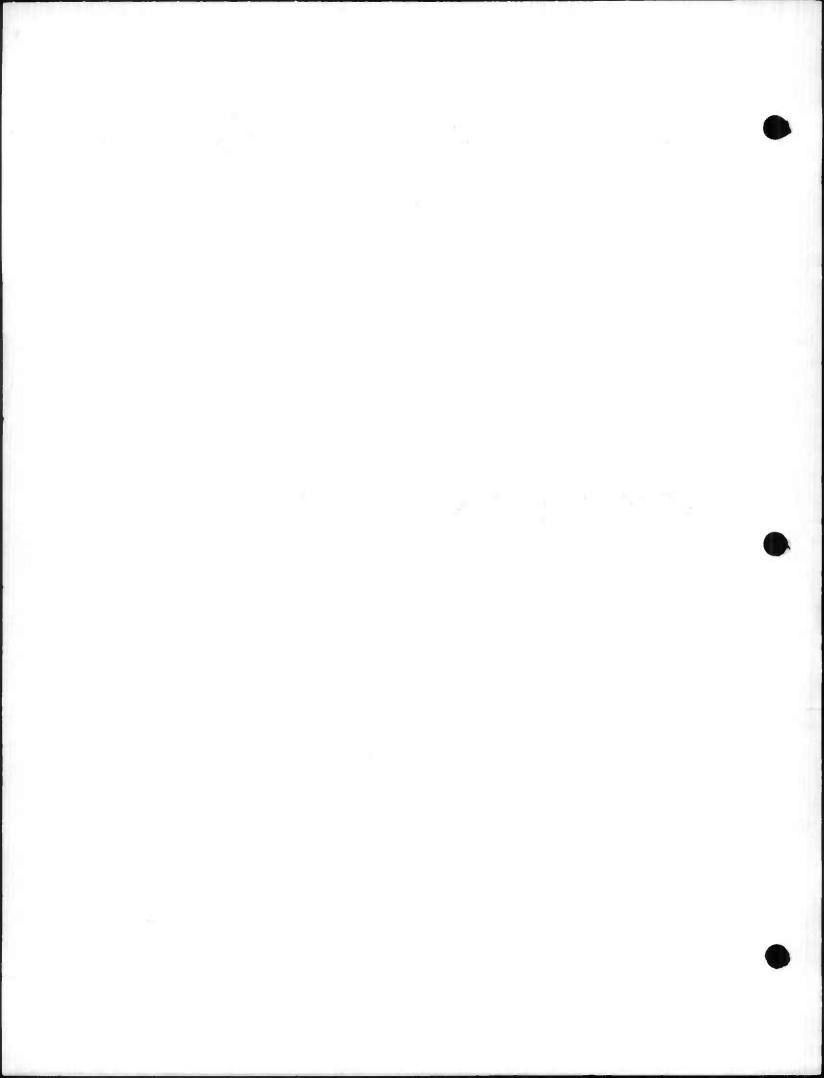
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'n,	Page nett o ny or	Н	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specification 5 ☑	Removal from State in state		y, cremerc	ory or other ple	ca)	į				
Baltimore,	permit. Page Department of Important: If any injury or otice.		21. Signature of Funeral Service Licar Ronald									imore	Street
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			30. Neme and address of person who	completed cause of de	eth (Item 23e) (Type, Prin	nt)		1		1/3	, ,	
			William P.	JONES	mI)	695	fr	tme	VICA	21	035	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO I. DECEDENT'S NAME /First, Middle, Laso 2. DATE OF DEATH 3. TIME OF DEATH 11:37 A . EA MARCH SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Dec. West 4-23-20 6. AGE /In urs. /ust birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreig 216-01-9611 DAYS HOURS MARYLAND 1 - MaXIF YRS permit. Pages 1, 2, 3 should Se. FACILITY HAME (If not institution, give street and number) Sb. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH GENSIS HEALTH CEN. LOCH RAVEN DIRECTOR TOWSON BALTO. CO. RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY IDE. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITET MARYLAND N/A BALTIMORE + K YES 2 □ NO 10e. STREET AND NUMBER FUNERAL 101. ZW CODE 10g. CITIZEN OF WHAT COUNTRY? 7101 EASTBROOK ROAD burial-transit 21224 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARKTAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCEST 1 YES 2 NO If yes, specify Cubin, Mexican, Puertir Rican, etc.)
1 1 YES 2 XNO Specify: 1 Never Married 2 Married 3 🔀 Widowed 4 🗌 Divorced BY Specify: use as the WHITE COMPLETED 15. DECEDENT'S EDUCATION wolfy only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done starting west of working 16a. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 2 College (1-4 or 5+) detached +2 SALES CLERK HUTZLER'S DEPT. once. 17. PATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Master Sumamul RAYMOND NELSON 2 ¥ HELEN ANDERSON BE notified director, page 5 should THE INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Revn., State, Zip Code) 2 MS. NORMA S. STRECKFUS OLD MAPLE CT. BALTO. MD. 21221 2 METHOD OF DISPOSITION

Burlet 2 Cremation 3 | He 206. PLACE AND DATE OF DISPOSITION /Name of 29c. LOCATION - City or Town, State DATE must REDEEMER CEMETERY3-27 4 Constitute of Funeral Service Licenses BALTO. MD. examiner 22. NAME AND ADDRESS OF FACILITY funeral KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. and completely filled in by the 21222 medicál 23. PART I. Enter the disea that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between b IMMEDIATE CAUSE (Final Onset and Death cramation, å disease or condition resulting in death) Acute </mont DIEUMONIA event. DUE TO (OR AS A CONSEQUENCE OF to burial, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING physician Dig. CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Mertal PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the MEDICAL 24s. WAS AN AUTOPSY 34h. WERE AUTOPSY FINDINGS 20 PERFORMED? WRILABLE PRIOR TO amy signed t COMPLETION OF CAUSE 1 YES 2 LAG Shows T TES 2 700 D 04 Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) them Stalls certificate HOSPITAL 1 YES 2 PHO 1 Impetient 2 I ER/Outpetiert 3 I DOA ince 6 () Other (Specify) 200 ö 27. MANNEN OF DEATH 28s. DAYE OF INJURY (Month, Day, Year) 29c INJURY AT WORK? 784. DESCRIBE HOW INJURY OCCURED ij marked, # 1 Returns 5 Pending I UVER 2 □ NO BY death Affect 2 Accident 28s. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) . 3 Suicide 281. LOCATION (Street and Number or Flurel Houte Number, City or Town, State) COMPLETED fi Could not be L DIRECTOR 4 Homicide 28 Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE PLOSPITAL OF THE FLANSPAL DE PROGRAMME Z HE INPORTANT. ST IN 2 MEDICAL EXAMINER: On the besis of so it, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 206. SIGNATURE AND TITLE OF CERTIFIER BE 3/26/98 032939 2 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print) BALTIMORE Pokenka 2914 THE 31. DATE FRED IMPON DO SHE 12. REGISTRAR'S SIGNATURE 13,00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey SAMORODIN HANNAH C. MARCH 29, 1998 7 AM 4e Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 8. Dete of Birth (1910) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birtholace (Stete or Foreign 1□ M 2□XF Months Deys Hours Min PATESTINE 88 Yrs. 196-28-6757 Usuei Residence of Decedent 10e. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County MARYLAND BALTIMORE 1 TYYes 2 □ No N/A 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21209 USA 6316 GREENSPRING AVE, APT. 106 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Rece - American Indien, Biack, White, etc. 1 Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify. 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SOCIAL SECURITY Elementery/Secondary (0-12) College (1-4or 5+) 12 SUPERVISOR ADMINISTRATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) MORRIS COHEN ELSIE LAPIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) DR. CHARLES SAMORODIN (SON) 1011 W. WIND COURT RUXTON, MD 21204 20b. Piece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriai 2 □ Cremetion 3 □ Removel from Stete GREATER BALTIMORE LODGE 3/31/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Limit 22. Name and Address of Fecility
SCL LEVINSON & BROS., INC. uny 8900 REISTERSTOWN ROAD BALTIMORE, MD 21208 the disease or complication that course the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, and failure. List only one cau and according Approximete Intervel Between Onset end Deeth ock, or h Immediate Cause If disease or condition resulting in death) metastatic carcinome of the broast Final LYCGY Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SCUR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 10 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28b. Time of 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 PNeturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Craffying Phyelcian: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and menner es stated. (Check only 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Dey, Year)

Box 68760 Records, P.O. 84 signed by t Deen Mai 100 08082 Pe certificate Division of Vital Physician: 書 After Attending 24 hours after deaf a Funeral Director. or A Hospital To the within 2 To the

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death ' Hygiena. rther than "neturel", or items 23

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other that eny Injury or other traumatic event, Inst. pncs.

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

edical

Baltimore, Maryland 21215-0020

Directo

by

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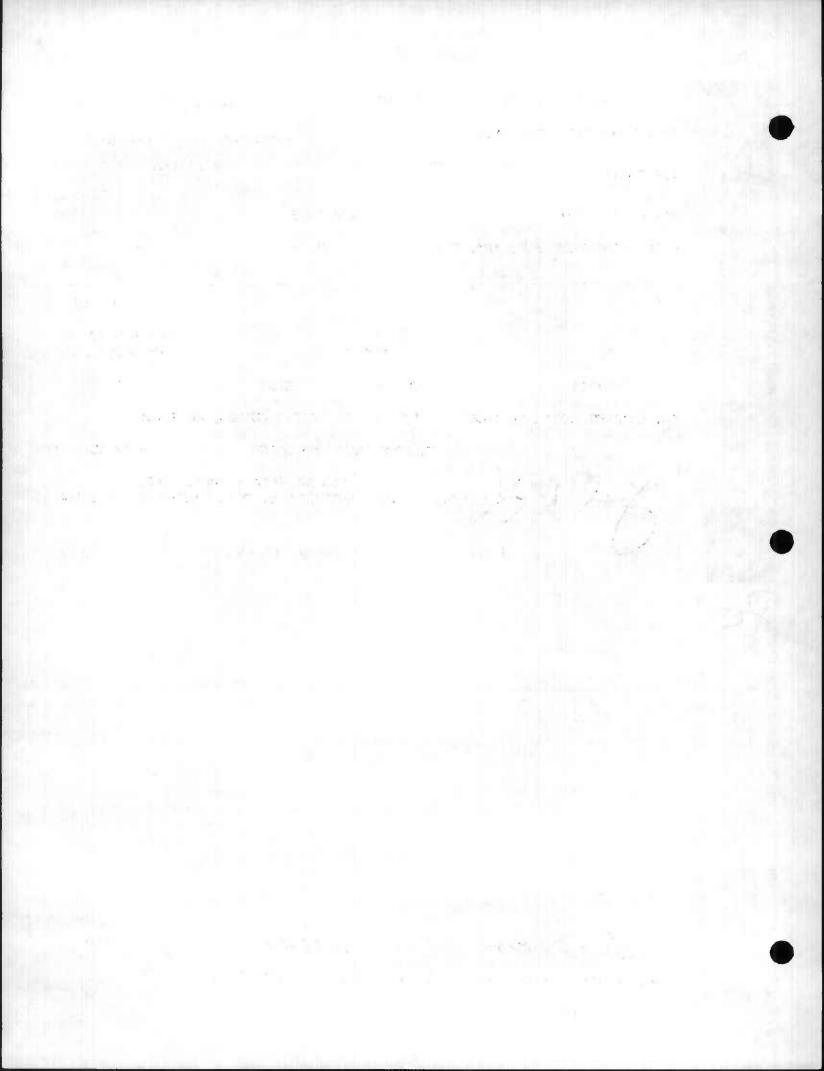
31. Date tiled (Month, Day, Year)

29b. Signeture end title of certifier

20. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

21 Cross roads Dr. Ocings mills md 21117 82, Registrar's Signature

State APR 02 1998 Registrar



TO BE COME	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPL
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows eny Injury, or other traumath, event, the medical examiner must be notified at once.	IMPORTANT: If Ite
val.	be filed within 72 hours after death with the State Dept. of Health and Mentai Hyglene prior to but a security or removal.	be filed within 72 hou
he funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and content filled in by the funeral director, page 5 should be detached	TO THE FUNERAL DIF
er death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exception and 24 hours after death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR
		2

David J. Pe 31. DATE FILED (MORITI, Day, Year) APR 02 1998

32 REGISTRAR'S SIGNATURE

							96	1039	4			
	1 - FOR STATE REGISTRAR	TATE OF MARYLAND /		MENT OF H		MENTAL HYGIEN REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Last)		55			2. DATE OF DEATH	AY YE.	3. TIME OF DEATH	1			
	Myer Saple	rstein				3 3			AM			
	4. SOCIAL SECURITY NUMBER 5. S. S. S. S. S. S. S. S. S. S. S. S. S.	BEX 8. AGE (In yrs. lest	birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	()	IRTHPLACE (State or Fore Jountry) RUSSIA	algn			
OR	9a. FACILITY NAME (If not institution, give street a JEWISH CONVALESCENT				R LOCATION OF DE. TIMORE	ATH	BALT	OF DEATH IMORE				
ᇈ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		40° CITY	, TOWN OR LOCAT	ION			10d. INSIDE CITY				
DIRECTOR	MARYLAND BAI	TIMORE	100. 0111	REIST	ERSTOWN			1 XYES 2 N	10			
FUNERAL	10e. STREET AND NUMBER 406 DEACON BROOK CIF	RCLE		10f	21136		U	OF WHAT COUNTRY?				
B	1 News Married 2 Married	WAS DECEDENT EVER IN U.S. ARI FORCES? 1 ∑Y YES 2 ☐ N IF YES, GIVE WAR OR DATES		If yes, spe		IC ORIGIN? (Specify Yea n, Puerto Rican, etc.) :		RACE — American Indien Black, White, etc. Specify: WHITE	٦,			
COMPLETED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary(Secondary (0-12) Co	eleted) (G/	ive kind of w Do NOT us	usual occupation ork done during mo retired.)	DN st of working	166. KIND OF BU		RY				
	17. FATHER'S NAME (First, Middle, Last) GERSHON	SAPPERSTEI	N		18. MOTHER'S NAI CHA	ME (First, Middle, Malden ISA	Surname) SUS	EL				
TO BE	19a. INFORMANT'S NAME (Type/Print) MR. PHILIP S. SCHINI	OLER (STEP-SON) 406	ADDRESS (Street a	nd Number or Rural F BROOK C	Route Number, City or Row IRCLE REIS	n, State, Zip Coo TERSTO	WN, MD 211	36			
	20s. METHOD OF DISPOSITION 1 10 Burlal 2 Cremetion 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cornetary, crematory or connector											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SCL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD BALTIMORE, MD 2120											
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate											
. 1	IMMEDIATE CAUSE (Fine)							Onset and				
	disease or condition a. Covolo pulluously failure Due to (or as a consequence of):											
/		DUE TO (OR'AS A CONSEC	DUENCE OF	D. 240	2000	Sener						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR'AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury That Initiated exercise DUE TO (OR AS A CONSEQUENCE OF):											
Ē	CAUSE (Disease or injury that initiated events resulting in death) LAST											
ER	resulting in death) LAST	Dementiq										
	PART II. Other aignificant conditions co			24b. WERE AUTOPSY FIN								
MEDICAL	IDDMTypeZ.	100000	PERFORMED? AMAILABLE PRIOR COMPLETION OF OF DEATHS									
AED	ASCVD	A	OF DEATH?	10								
IAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? MOSBITAL: OTHER:											
Sic	110	OSPITAL: Inpatient 2 ER/Outpatient 3	□ DOA	OTHER: 4 Nursing Hon	e 5 🗆 Residence	8 Other (Specify)						
BY PHYSICIAN:	27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation	URY AT DRK? YES 2 NO	28d, DEŞCRIBE HOW INJURY OCCURED 0									
	3 Suicide 8 Could not be 4 Homicide determined		LOCATION (Street and Number or Flural Flourie Number, City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											
ш	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI	MBER	29d. DATE SI	GNED (Month, Day, Year)						
m	David J. tem	1 MID			D299	18	331 48.					
ТО	David J. Penn	36350 of CFR	M 27) (Type	wite 610	Pikewil	leMD212	08.					
				- 1M								

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death March **Physician** Evelyn Sandler 4:301m 27,1998 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Sinai Hospital, 2401 west Belodere henne N/A Baitimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. April 7987026 5. Sociel Security Number 7. Age (In yrs. last birthday) 71 Yrs. 6. Sex **Funeral** 220-14-3173 1 □ M 2 🖾 F MARYLAND Director Usuel Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show MARYLAND N/A 1 ¥ Yes 2 No BALTIMORE Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2500 W. BELVEDERE AVE, APT. 402 21215 USA deeth Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. filed within 72 hours efter of Hygiene. 1 Never Merried 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☑ Divorced WHITE r than "natural in Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) TEACHER EDUCATION permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, important: if item 27 is marked othe any injury or other traumatic event, once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be LOUIS TRETICK ROSE SCHWARTZ 9 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. NORINE KERBEL (DAUGHTER) 4 HUNT MEADOW CT. OWINGS MILLS, MD 21117 20b. Placa of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State cemetery, cremetory or other piece)
HEBREW YOUNG MENS 3-29-1998 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licans 22. Name end Address of Fecility
SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD BALTIMORE MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory enters shock, or heart feilure. List only one cause on each line. Congestive Heart Failure

Due to (or es e consequence of):

Cardic my o pathy

Due to (or es e consequence of):

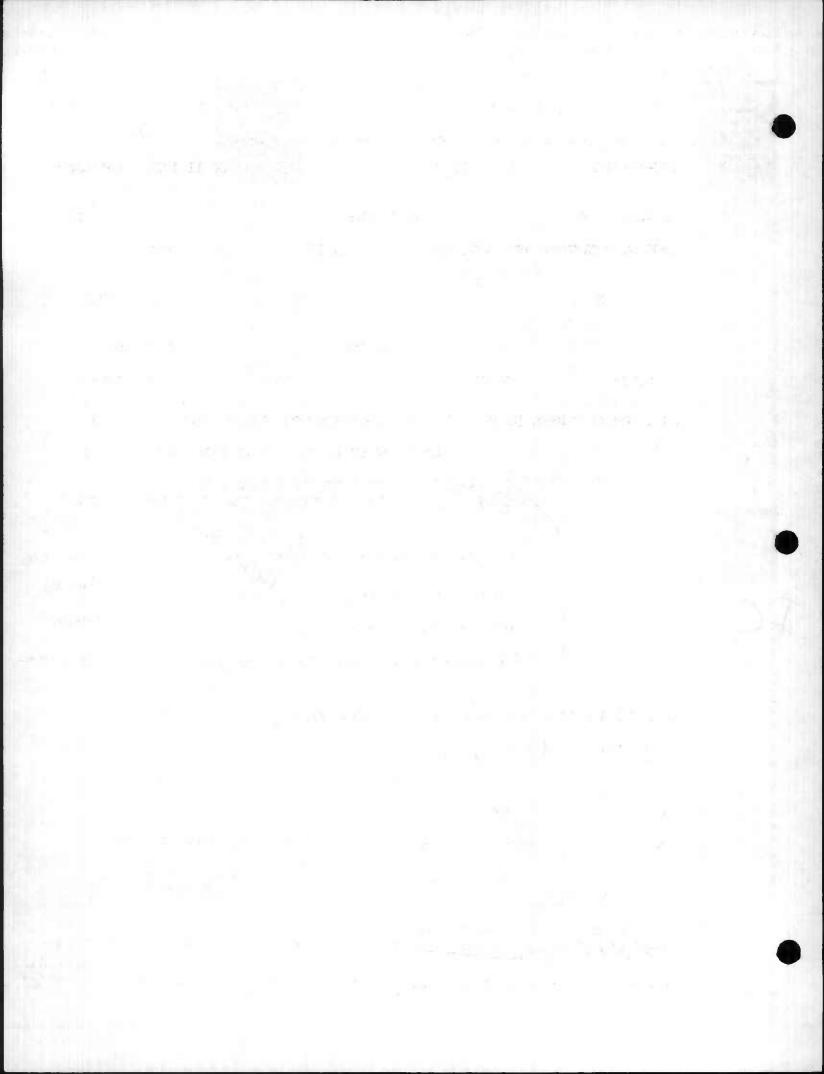
Am'al file: 11.4. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 3 months Examiner Examiner 3 months Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest 3 months Am'ai filmillation
Due to (or as a consequence of): Physician/Medical Rib fractures secondary to fall one week Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown S/pcVt, S/p myocardial infarction, 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Digitalis texicity. 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital i or Attending Physician: after death. Director: After this certifice 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Mnpatient 2 □ ER/Outpetient 3 □ DOA 28c. Injury et Work? Certification: 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 1 Naturai 5 Pending Surstour per. 1 Yes 2 No MARCH 17,98 UNK 2 Accident 3 Suicide Investigation 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
NURSING HOME 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 515 BRIGHTFIELD ROAD 4 - Homicide 24 hours a BROKLANDVILLE MD.

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Hospitai To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Intern in Intemp medicie A52402321 AMASI6 march 27, 1998 Baltmire 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Hospital, 2401 West Belvedere trein ne manyland Anna Amaham, pro sinai 32. Registrer's Signature 31. Dete filed (Month, Day, Yeer) APR 02 1998

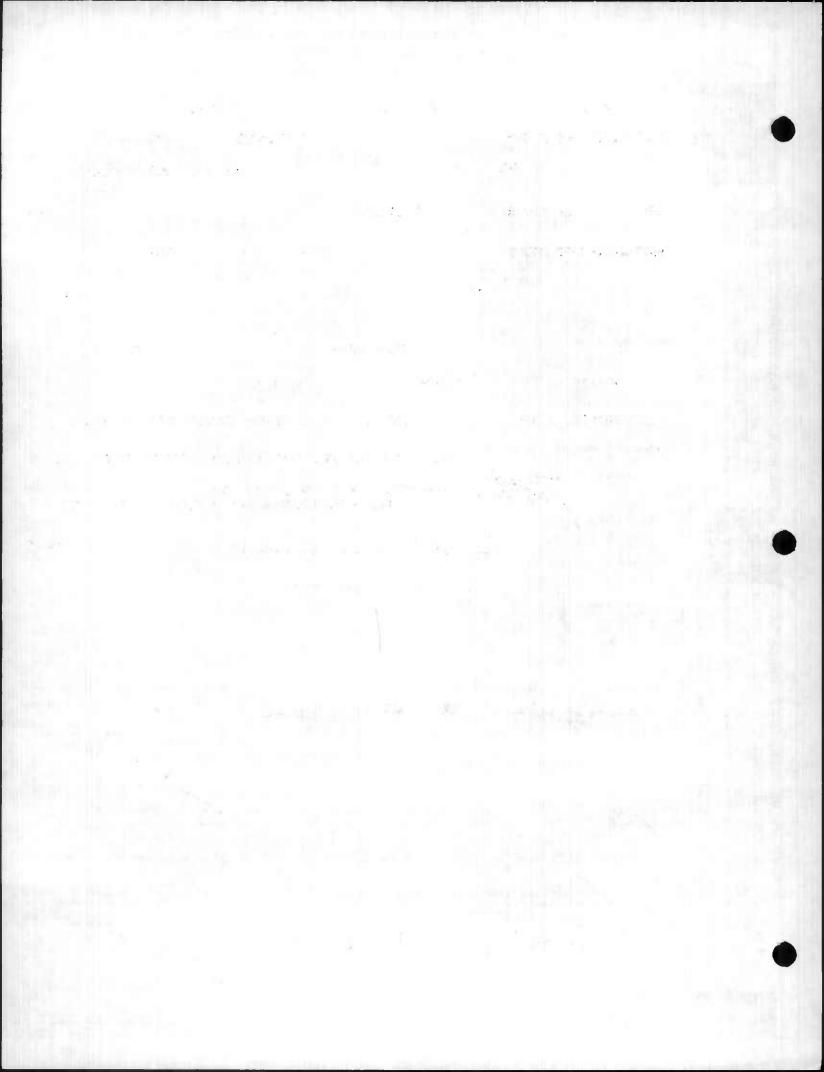
DHMH 16 Ray 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene 98 10396

				C	ertifica	te of I	Death		F	leg. No.			
	140-								2. Dete of Dea		Yeer	3. Tima of Death	
Physician /Medical	SADIE SHAPIRO								MAR.2			4:45 PM	
Examiner	4e Fecility Neme (If not institute 3402 WINTER		d number)		4b. City, Town, or BALTIM					th 4c. County of Deeth BALTIMORE		Œ	
Funeral Director	5. Social Security Number 217–50–0755	6. Sex 1 ☐ M 2 🔯		yrs. lest birthda Yrs.	y) If Unde Months	Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, De) OCT . 31			olece (Stete or Foreign htry) AND	
and and and and and and and and and and	Usuel Residence of Decedent 10e. State 10b. Cou			City, Town or	Location IMORE						1	0d. Inside City Limits	
be nottled Director	10e. Street end Number			DAUI		p Code				10g. Citizen of	What Cour	1 ☐ Yes 2 💢 🎉	
ustba ustba	3402 WINTER					212				USA			
ione. The Madical Examiner must be notified at Ompleted by Funeral Director	3 □ Wijdowed 4 □ Divor	Arme	Decedent Ever i d Forces? les 2 (19) i, Give or Detes:	n U,S. 1.	If Yes, spe		Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	Specify	ce - Americ ck, White,		
ygiene. or than "natura t, the Medical I	15. Dece (Specify only high	dent's Education ghest grade complet		(Gi	edent's Usu ve kind of wo DO NOT u	ork done o	durina mos	t of work	ing	16b. Kind of B	usiness/Ind	dustry	
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ava dot	17. Fether's Neme (First, Midde MORRI.		FR	ANKEL				er's Name CHEL	e (First, Middle,	Meiden Sumen UNKNO			
Ema	19a. Informent's Neme/Releti	onship (Type, Print)		19b. Ma	iling Addres	s (Street	end Numb	er or Run	al Route Numbe	r, City or Town,	Stete, Zip	Code)	
1 t	ALVIN SHAPI	RO / SON	lee				PRING	S RD	; LUTHER				
늘	20e. Method of Disposition 1 Trapriel 2 Cremeti 4 Donation 5 Other		rom State	b. Plece of Dis cemetery, c ARLINGI	emetory or	other plea) M	Dete AR. 29,	20c. Location			
Departmen important: any injury once.	21. Signeture of Funerel Serv	ice Lightsee	1		22. Neme e	nd Addre	ss of Fecili	BRO	S, INC.			1037 110	
ysician	23a. Pert1. Enter the diseese shock, or heert feilure.	complications the only one cause	nat caused the con each line.	death. Do not o	8900_] inter the mo	REIST de of dyin	CERSIX ng, such es	Cerdiac	RD: PTKI or respiretory er	SSVII_I.F.	,—MD-	21208 Approximete Intervet Between Onset end Death	
dedical aminer	Immediate Cause (Finel disease or condition resulting in death)	θ.	Due !	to (or es e cons	equence of)		Ace	تعامر	+			2-3dy5	
d ansit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of):												
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gned by the be detach by Phy	Cancer of leteurs with metastic Di							1□ Yes 2□ No 3□ Probet					
2 should pleted										en eutopsy med?	ev	ere eutopsy findings reilable prior to empletion of ceuse deeth?	
Com									101	es 42No	1[□Yes 2□No	
director, par fo Be Co	25. Wes cese referred to med exeminer?	Hospitet:				Oth	an-		h (Check only o				
5 7	1 Yes 2 No	28e. D	ate of Injury	28b. Time						tome 5 Passidence 6 □ Other (Specify)			
al Diractor: After the in by the funeral Certification:	27. Manne of Death 1 Naturel 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Date of Injury - At home, ferm, street, fectory, office 28d. Describe how injury occurred Work? 1 Yes 2 No 28e. Date of Injury - 28b. Time of Injury et Work? 1 Yes 2 No 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work? 28e. Describe how injury occurred work?									al Route Number.			
	4 Nomicide	6	uilding, etc. (Sp	ecify)				4-1	City or Tox	m, Stete)		She:	
pletely fill edical		lying Physician: To cal Examinar: On the end r											
To the comp	29b. Signeture and title of cer	tifier N	ml	w	29	C. Licens	802	29		29d. Date signe	28 C	Day, Year)	
1	30. Neme and address of pers	on who completed	cause of deeth	Item 23a) (Typ	e, Print)	-			0	るいかの	5 1	MILLS	
0	JAY S. MA	AKGOLI.	5 70) -+ · P	AINT.	PRS	MI	4	SKD	MARI	1LA	MILEO	
State	31. Dete tiled (Month, Dey, Ye	er)	2. Registrar's S	igneture									



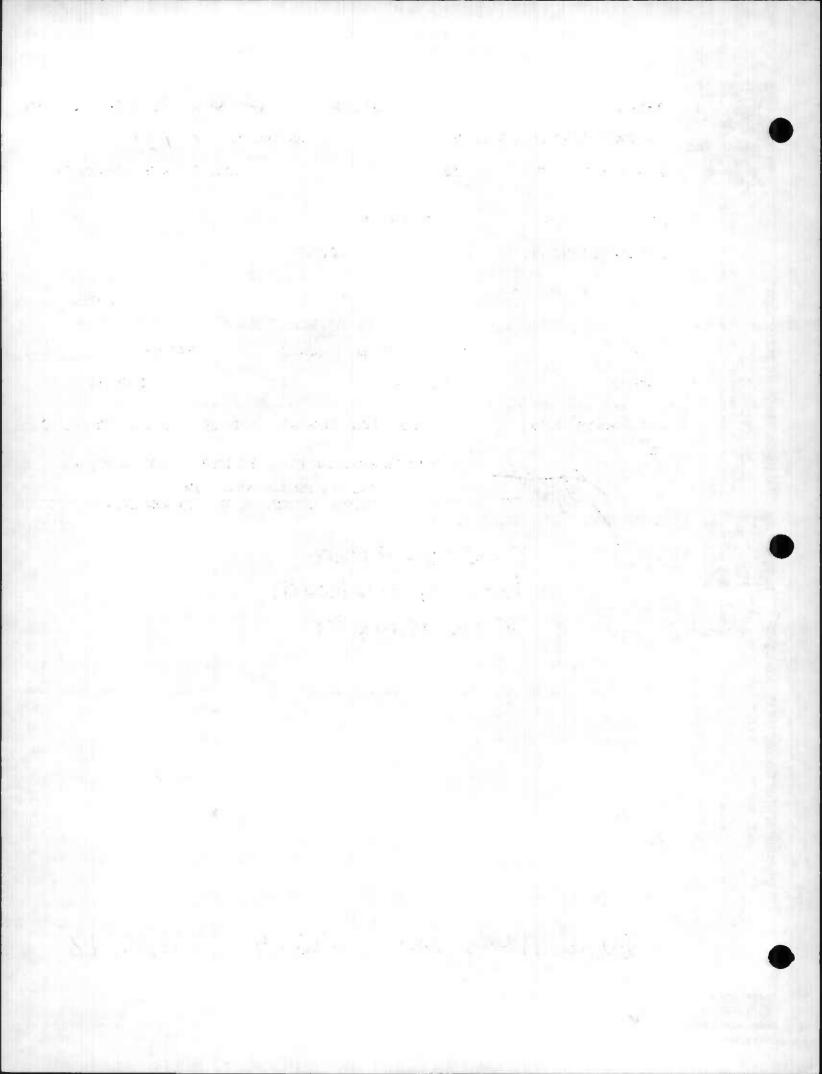
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** MORTON SANDLER MARCH 30 1998 1:10 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 200 CROSS KEYS RD., APT. 29 BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC. 27,1916 5. Sociei Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9 Birthplace (State or Foreign 6 Sax **Funeral** 1√2 M 2□ F Months Deys Hours MARYLAND 217-14-5026 81 Director Usuel Residence of Deceden the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a Stete 10b. Counts show than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Director N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number with 200 CROSS KEYS RD. APT. 29 21210 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 12 Yes 2 No If Yes, Give 14. Race - American Indian, 11 Marital Status Black White, etc. filed within 72 hours after thygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: à WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If item 27 is marked of HYMAN SANDLER IDA SHOCKET 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) ANN SANDLER (WIFE) 200 CROSS KEYS RD., APT. 29 21210 BALTO., MD item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from Stete 들 permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 3/31/98 RANDALLSTOWN, MD 21. Signature of Funerel 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 9900 REISTERSTOWN RD., PIKESVILLE, MD 21208
To complications thet caused the deeth. To not enter the mode of dying, such as cerdiac or respiratory arrest,
Approximate list only one cause on each line. 23a. Pert1. Enter the Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner monary Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anour Division of Vital Records, P.O. Box 68780 edical Due to (or as a consequence of) Physician/M b 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. ď 1 Yes 2 No 3 Probably 4 Unknown bengs d be de þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed' page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate Be 25. Was cese referred to medical 26. Piece of Death (Check only one) xeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 98 28c. Injury at Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1 Netural or Attending 5 Pending 1 Tes 2 No investigation 2 Accident after deal Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 24 To the To to the To the Complet 29c. License number 29d. Date signed (Month, Dwy, Year) 29b. Signature and fitte of certifie euse of death (Item 23a) (Type, Print)

SMD, 21 CR 0SSR0ADS DR #250

Redistrar's Signature Randow State

Registrar



DAMTAN

State of Maryland / Department of Health and Mental Hygiene

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tificate of Death	Reg. No.	3	U		0	0	9	-
riment of Health and Menta	raygierie	0	Q	1	0	0	0	

	444	. 4	
SPF	RIG	GS	

Physician /Medical Examiner

NA

Funeral Director

with the Maryland

f is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene.

Importunit if item 27 is marked other than "not any injury or other traument—

Physician /Medical Examiner

Division of Vital Records, P.O. Box 6876 987 2 page 2 certificate director. Bills funeral Affor Attending after death.

b

Hospital Funeral

within 2 å

10a State MD Directo 10e. Street end Number Funeral 11. Marital Status þ Completed Isiah edical Physician/M þ Completed 88 20 1 No Yes 2 No 27. Menner of Deeth Certification: 1 Naturel 2 Accident

1 Decedant's Name (First Middle Last) 3. Time of Deeth 2. Dete of Deeth Month Yeer Damion Lionel Spriggs MARCH 26,1998 10:30P.M. 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 500 NORTH STREEPER STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 01-30-70 Birthpiace (Stete or Foreign Country)
 MD • 5 Social Security Number 7. Age (In yrs. lest birthday) Months XXM 2□F Deys Hours Min 28 Yrs. 216-88-8746 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore Wes 2□ No 10f. Zip Code 10g. Citizen of Whet Country? 210 North Belnord Avenue 21224 USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, atc. 1 ☐ Yas 2☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16e. Decadent's Usuel Occupation
(Giva kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elamentary/Secondery (0-12)
11th grade College (1-4or 5+) Security Guard Durbar Security Co. 18. Mothar's Name (First, Middle, Maidan Sumeme) 17. Father's Neme (First, Middla, Last) Spriggs Marlene Cornish 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Marlene Spriggs 210 N. Belnord Ave., Balto. Md. 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 15 Buriel 2 Cremetion 3 Removel from Stete King Mem. Pk. 4/3/98 4 ☐ Donetion 5 ☐ Other (Specify) Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave. Masch F.H. East 23a. Part . Enter the disease, or complications that caused the deals Do shock, or heart failure. List only one cause on each line. hot enter the mode of dying, such as cardiac or respiratory arrest, Approximeta Intervel Between Onset end Death Immediata Causa (Final diseese or condition rasulting in daath) MULTIPLE QUISHOTWOUND) Dua to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceusa (Disaesa or Injury that initiated avants resulting In deeth) Lest Dua to (or as a consequence of): Due to (or es e consequence of) Part II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an eutopsy performed?

24b. Wera autopsy tindings available prior to complation of cause of daath?

1 ¥ Yes 2 □ No 26. Placa of Daath (Check only one)

1 TyYes 2□ No

25. Was casa raferred to medical examiner?

H MYDR HD

5 Pending Investigation

6 Could not be determined

Hospital:

28a. Date of Injury (Month, Day Year) 98 26

28b. Tima of 22:10PM 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \notice Other (Specify) SCENE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred Surs JETT WAS

SHOT 28f. Location (Street end Number or Rurel Route Number City or Town, Stata)

29a. Certifies (Check only one)

3 Sulcide

4 Homicide

STREET 500 N. STREEPER ST BALAMONE MA 1 Cartifying Physician: To the best of my knowledge, daeth occurred et the time, dete end plece, end due to tha causa(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred et tha tima, date end place, and due to the cause(s) end menner stated. 29c. License number

29b. Signeture end title of certifier

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 27,1998

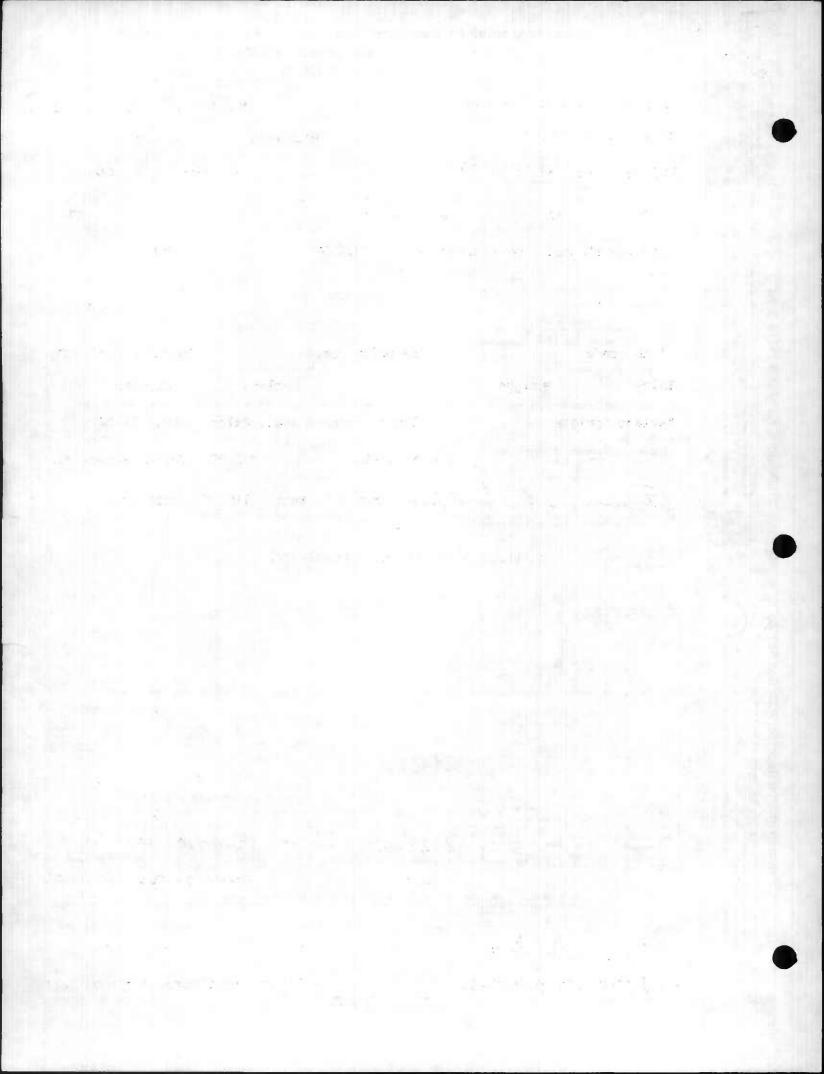
la 30. Nama end address of person who complated cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

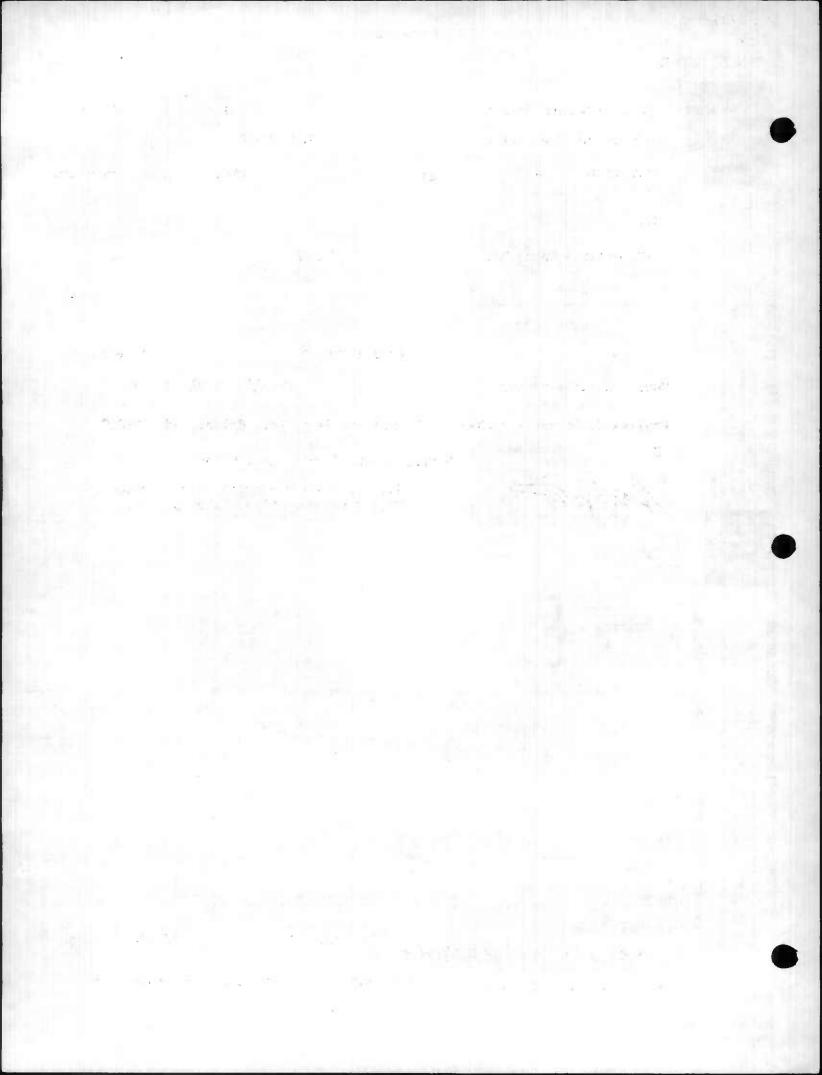
State Registrar

31. Data tiled (Month, Day, Year) 02 1998





KENNET		Items: 23 part I,27,28a-	f per MEO G-758 4/16	Pertificate of		Re 2. Dete of Deeth	g. No.	103	ime of Death
	ician	Kenneth Howard S	etzer			Month MARCH	Day	Yaar	30 PM
Ψ.	edical niner	4a Facility Name (If not institution, give stre			4b. City, Town, or Loc		4c. County	of Death	JU FFI
		3102 HOLLINSFERRY			BALTIMORE		BALT	IMORE	
Fune Direct		5. Social Security Number 219-70-2779 Usual Residence of Decedent	7. Aga (In yrs. last birthe	Months Days	Hours Min.	8. Date of Birth (Month, Dey,)EC. 31,	Year) 1957	9. Birthplace (S Country) Mary 18	State or Foreign and
the Maryland	ctor	10a, Stele 10b, County Md. BALTIMORE	10c. City, Town of BALTIMO						Side City Limita Yes 277 No
th with th	ai Director	10e. Street and Number 3100 Hollins Ferr	y Rd.	10f. Zip Code	1230	10	g. Citizen of W	What Country?	
ter dea	by Funeral	11. Marital Status 12. ↑□ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Yaar or Dafes:	13. Was Decadent of I If Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto R	ify Yes or No- ican, atc.)		a - American Ind k, Whifa, atc. Whit	
		15. Decedent's Educat (Specify only highest grade of Elemantary/Secondary (0-12)	College (1-4or 5+)	ecedent's Usuel Occu Give kind of work done de. DO NOT use retire AUTO Mechar	during most of working d)	9 1		siness/industry	2
be file dothe	Be	12 17. Fether's Name (First, Middle, Last) Robert William Set		1000 Nechal	18. Mother's Name	(First, Middle, M	eiden Sumem	Θ)	
s 1 end 2 should be I Health end Mentel Item 27 is marked o	2	19a. Informant's Name/Relationship (Type,		felling Address (Stree	t and Number or Rural)
C C N L		Phyllis C. Setzer	- mother 31	Hollins Fe	erry Rd., E			1230	
Page nent o		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donetion 5 ☐ Other (Specify)	oval from State cemetery,	isposition (Name of cremetory or other ple Heart of	Jesus Cem.	Date 2 01/98		City or Town, Si	
Physica /Medic	an al er	Immediate Cause (Final disasse or condition resulting in deeth)	aura A. Dexter ions that caused the death. Do no beuse on aach line. CIRRHOSIS NARCOTIC INTOXICAT: Due to (or as e co	7250 Washir enter tha moda of dy	Jfman Funei ngton Blvd. ing, such as cardiac or	ral Home . Elkrid respiratory arre	@ Mea lge, Md	dowridge 2107: Appro-Inten Onse	
Bcuted end -transit	xaminer	Sequentially list conditions, if eny, leading to immediate	Due to (or es e co	nsequenca of):	·				
BOX 00/00, eath certificate be executed attending physician enforuse es the burial-tr	Physician/Medical Ex	cause. Enter Underlying Ceuse (Diseese or Injury thet indiated events resulting in death) Last	Due to (or es e con	nsequenca of):					
attending for use	lany	d							
thet the deaded by the all deteched for	Physi	Part II. Other significant conditions contrit	outing to death but not resulting in t	ha undarlying cause g	iven in Pert I.		s 2 No	al Probably	42 Unknown
aw requires to be a sign sign sign sign sign sign sign sign	Completed by					24a. Was ar perform	autopsy ed?	eveilable	on of cause
The The page	Com					1⊠ Ye	s 2 No	1. Yas	2 No
Physician: The this certificate rel director, pag	Be	25. Wes case referred to medical axaminar?	pitel:	_ 0	28. Plece of Deeth				
	To	IX THE ZUNO	28a. Date of fnjury 28b. Tir	ne of p 28c. Inju	4 LI Nursing Hor	e 5XXReside 8d. Describe ho			
Attending I r death. ector: After by the fune	ation	2 Accident 5 Pending Investigation	ound 3/27/98 found	3:20 M 1		ubject ing	gested di	rugs	
SE 5 5	Certification:	4 Homicide	28e. Plece of Injury - At home, fam building, etc. (Specify) ound at home		2	8f. Location (Str City or Town Ba	eet end Numb Stete) 3102 alcimore		ERRY RD.
Hospital A hours Funeral	edicai	(Check only 20 Medical Examiner	an: To the best of my knowledge, or the basis of examination and/						ause(s)
To the Hospital within 24 hours. To the Funeral Completely filled	Med	29b. Signature and title of certifier	and mannar stated.		se number	29		d (Month, Dey, 1	
		30. Neme and eddress of person who comp	7.7		reet, Balti	more. M	arvlan	1 21201	
			32 Registrar Signature		.cc, Miles	THOLO, I	ALL LUIN	_ 4,201	
	State	31. Date filed (Month, Dey, Year)	32 Registrar Signature						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Jeanne R. Shirley 4b. City, Town, or Location of Death 30, 1998 4c. County of Death 4a Facility Nama (If not institution, giva street and number) GIEN BURNIE If Undar 24 Hrs. 8. Data of Birth A.A.COUNT HRUNDEL HOSPITAL 8. Data of Birth (Month, Day, Year) Aug. 23,1927 5. Social Sacurity Number 216-20-7058 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Months Days Hours Maryland Usuai Rasidanca of Decedant 10a Stata 10h Count 10c. City, Town or Location 10d. Insida City Limits Maryland Anne Arundel Pasadena 1 Yas X No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 917 Duvall Hwy. 21122 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ᠫ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2X No Specify: White Specify: 3☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) Collage (1-4or 5+) Cook N.S.A. 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Thomas Barry Mary J. Abell 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 917 Duvall Hwy. Pasadena, Maryland 21122 Mary L. Riegel Daughter 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1 DKBurial 2 Cramation 3 Removal from State Glen Haven Mem. Park April 3,1998 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) M2CUTTY FOTYHIRK Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 21. Signatura of Funaral Sarvice Licanses me ant : Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximata Interval Batween Onsat and Death RESPIRATORY FAILURE Due to (or as a consequence of): RONIC OBSTRUCTIVE LUNG DISEASE immadiata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarfying Cause (Disease or injury that Initiated events rasulting in daath) Last Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Tyas 2 No 1 Yas 2 No 25. Was casa ratarred to medical 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant

Examiner Division of Vital Records, P.O. Box 687605 Physician/Medical py Completed page 2 certificate Be Certification: To 178 Athor Attending death or Attend after death Director:

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

th and Mental Hygiane. 7 is marked other than "natural", or fema 23a or 28a-f ehov traumatic event, the Medical Examiner must be notified at

with the Maryland

filed within 72 hours after death

Pages 1 and 2 should be f nant of Health and Mental I int: If Item 27 Is marked of

Important: If It any Injury or

Physician

/Medical

Examiner

JEANNE SHIRIE

3 Suicida 4 | Homicida

6 Could not ba

28a. Piaca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

😢 Certifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signal of and titia of cartifiar

29a. Certifier

(Check only one)

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Name and addrass of person who completed cause of death (ttam 23a (Type, Print)

APR 0 2 1998

31. Date filad (Month, Day, Year) Okeh

1407/2 fol Registrar's Signature

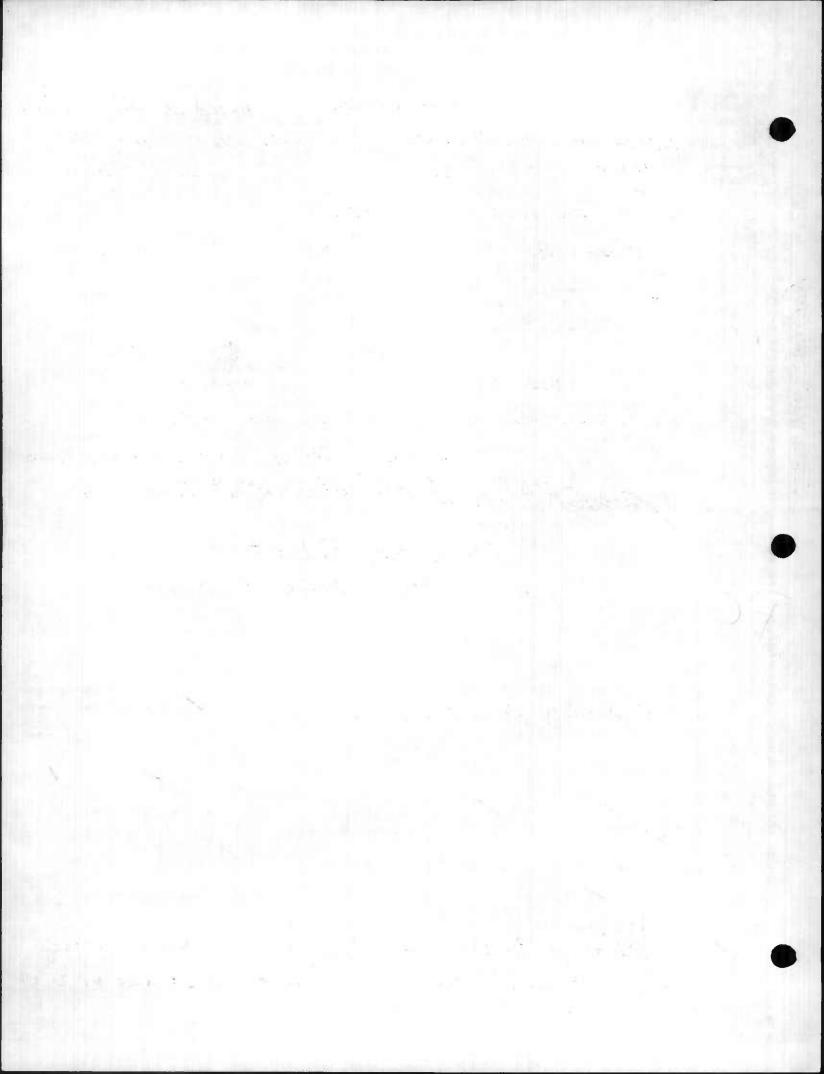
etuni,

State Registrar

24 hours after Funeral Dire

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within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth **Physician** Month MARCH /Medicai 4a. Facility Name (If not institution, give street end number, 4b. Clty, Town, or Location of Death 4c. County of Deat **Examiner** BALTIN If Under 24 Hrs. BON SECULIA Security Number 8. Dete of Birth (Month, Day If Under 1 Yeer 6. Sex Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** 1□M 2□ Months Days Hours 240-34-2064 Usual Residence of Decedent Yrs. Director death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If itam 27 is marked other than "natural", or items 23a or 28a-f ahow Injury or other traumatic event, I'm Medical Examiner must be notified at 1 ₽ Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiena. Important: if fam 27 is marked other than "natural", or items 23a any Injury or other traumatic avant Funeral 11. Marifal Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca Raca - American Indien, Bieck, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ₺ No Specify: by Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 77157NA2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme, Be 5RNON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of gemetery, cremetory or other place 20a. Method of Disposition ,Date/ 20c. Location City or Town, State 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 与 ☐ Other (Specify) 21. Signature of Plinaral Service License 23a. Pure the disease, or complications that caused the deeth. Do not enter the mode Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 11000 Examiner Due to (or as a conse ding physician and se as the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (c atten been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 has 1 Yes 2 No this certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Lo 1 Yes 2□ ER/Outpatient 3□ DOA Inpatient. 27. Manne of Death 28d. Describe how injury occurred 28b. Time of Medical Certification: Affer To the Hospital or Attending within 24 hours after death.

To the Funeral Diractor: Afte completely fled in by the fund 1 Natural Accident 5 Pending investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and fitle of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer)

Signatury Son-Randage

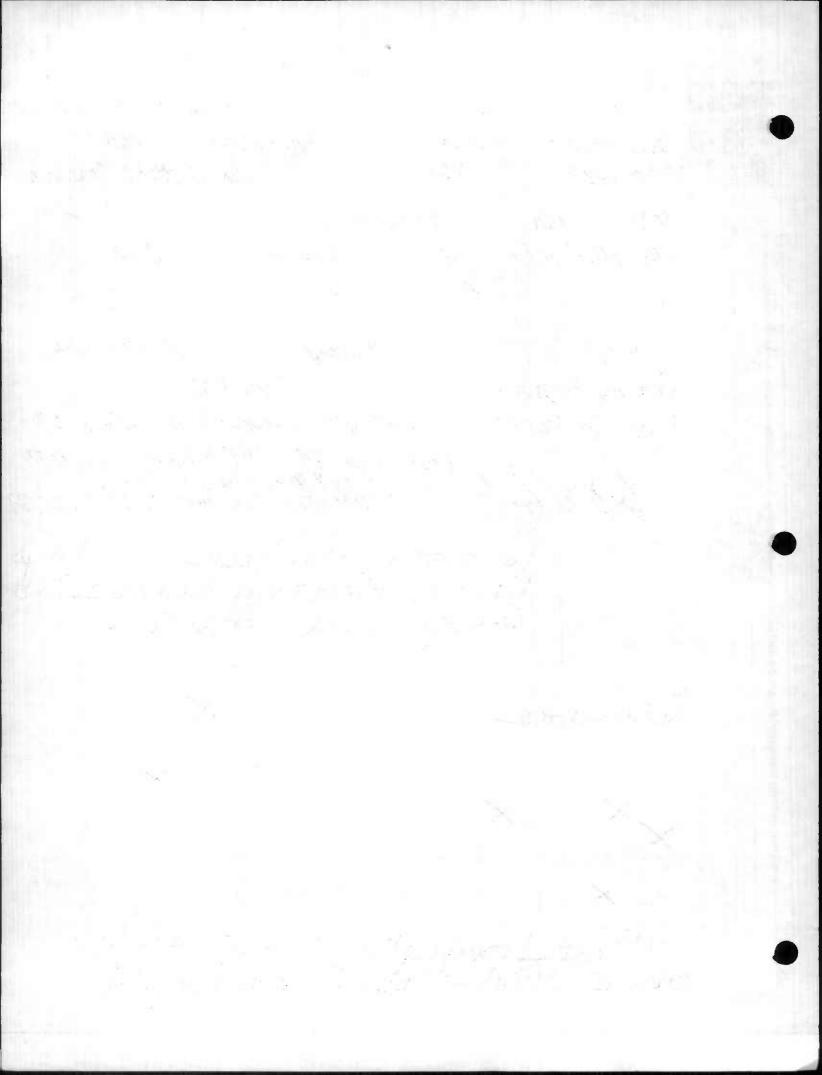
Registrar

State

30. Name end eddress of person

31. Date filed (Month, Dey, Yeer)

APR 02



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Item: 29d Per Film G-758 4-2-98RC State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death March 18, **Physician** 11:19 pm Smith Sylvia Mae /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick 6217 Derby Drive Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Hours Min 1□M 2X0 F Yrs. 85 May 1,1912 West Virginia Director 214 38 3416 with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f ahow Medical Examiner must be notified at 1 Yas 2 No Maryland Frederick Directo Frederick 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 6217 Derby Drive 21703 USA pemit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Examines mass page. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yaer or Dates: 14. Reca - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Maritel Status 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: by 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) School Teacher Baltimore County 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Be Hardin James A. Webb Viola E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 6217 Derby Drive Frederick, Maryland 21703 Duane Musgrove (grandson) 20b. Plece of Disposition (Neme of cemetery, crematory or other place)
Moreland Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramovei from Stete 3/21/98 Baltimore, Maryland 4 Deponetion 5 Other (Specify) 22. Neme end Address of Fecility
Bruzdzinski Funeral Home PA eture of Funerel 1407 Old Eastern Ave Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) no concinomy to liver

Due to (or es a consequence of)

Due to (or as a consequence of):

Examiner

Physician/Medical Examiner 88

ettending physician and for use as the burial-transit that the deeth certificate be executed ed by the e signed by t The law requires should t page 2 s certificate this funeral After

by Completed Hospital or Attending Physician: Be 10 Certification: death. I Director: A after filled in 24 hours e edicai

Box 68760 Division of Vital Records, P.O.

> State Registrar

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Lest Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of causa of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 PAesidenca 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28h Time of 28c. Injury et Work? 5 Panding 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rurel Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Day, Year) 3/19/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

7th Sta Frederick MD 21701

Inamy 31. Dete filed (Month, Dey, Year,

29b. Signatura and titla of dertifier

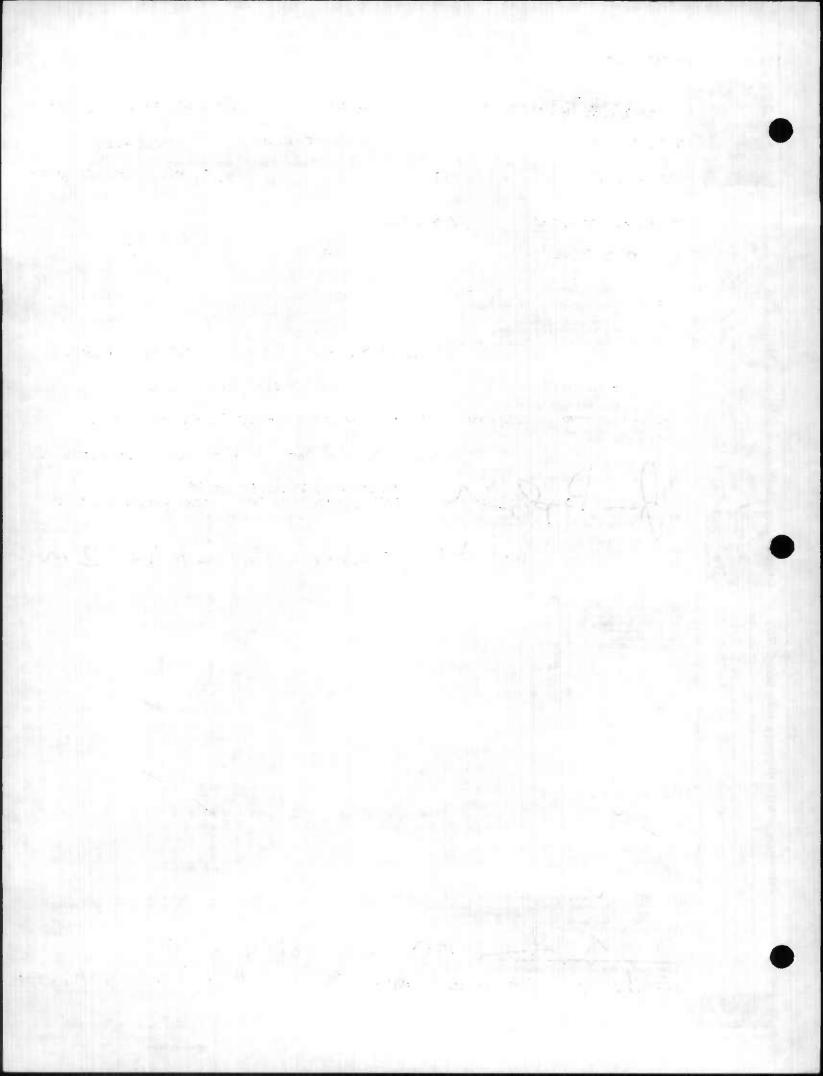
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month Yaar **Physician** IRENE REGINA SHANAHAN MARCH 27, 1998 2:00A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Undar 24 Hrs.
Hours | Min. | 8. D. 1827 McHENRY STREET N/A If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1 M 20 F Yrs. 235-38-1388 72 6, 1925 Director W. VIRGINIA Usual Rasidanca of Decedant with the Maryland 10d. Inside City Limits r 28a-f show 10a, Stata 10b. County 10c. City, Town or Location Yas 2 No N/A BALTIMORE Directo 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23s or solical Examiner must be 1827 MCHENRY STREET 21223 U.S.A. death y Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiena.

Interest if item 27 is marked other than "natural; or ite into yor other traumatic event, fire Medical Eventine into or other traumatic event, fire Medical Eventine. 1 ☐ Yas 2 ☐XNo If Yas, Giva Yaar or Dates: 1 Navar Marriad 2 Married 1 Yas 2 XNo Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementery/Secondary (0-12) Collega (1-4or 5+) SALES CLERK SHOE INDUSTRY 12TH GRADE 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) TALMAGE SHRADER VICIE MITCHEM 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1827 McHENRY STREET - BALTIMORE, MD. 21223 PHILLIP SHANAHAN (HUSBAND) altimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata important: If its 20a. Mathod of Disposition Date 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) CEDAR HILL CEMETERY 3/30/98 BALTIMORE 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hand failure. List only one between each line. Approximeta Intarval Batween Onset and Daath **Physician** Immadiate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disease or Injury physician s the burial Box 68760, the death certificate be that Initiated avants rasulting in death) Last Due to (or as a consequence of): attending p 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown 6 that ò The law requires 24b. Wara autopsy findings availabla prior to complation of cause of death? should b 24a. Wes an autopsy performed? Completed nas. page 1 Yas 20 No 1 Yes 2 No cartificate Physician: 25. Was case referred to medical axaminar? director. Be 26. Place of Death (Check only ona) Hospitel: Othar: 4 Nursing Homa 5 Rasidenca 8 Othar (Specify) 0 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Certification: 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 ☐ Could not be 3 Sulcida 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

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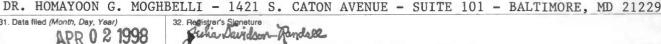
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29a. Cartifier

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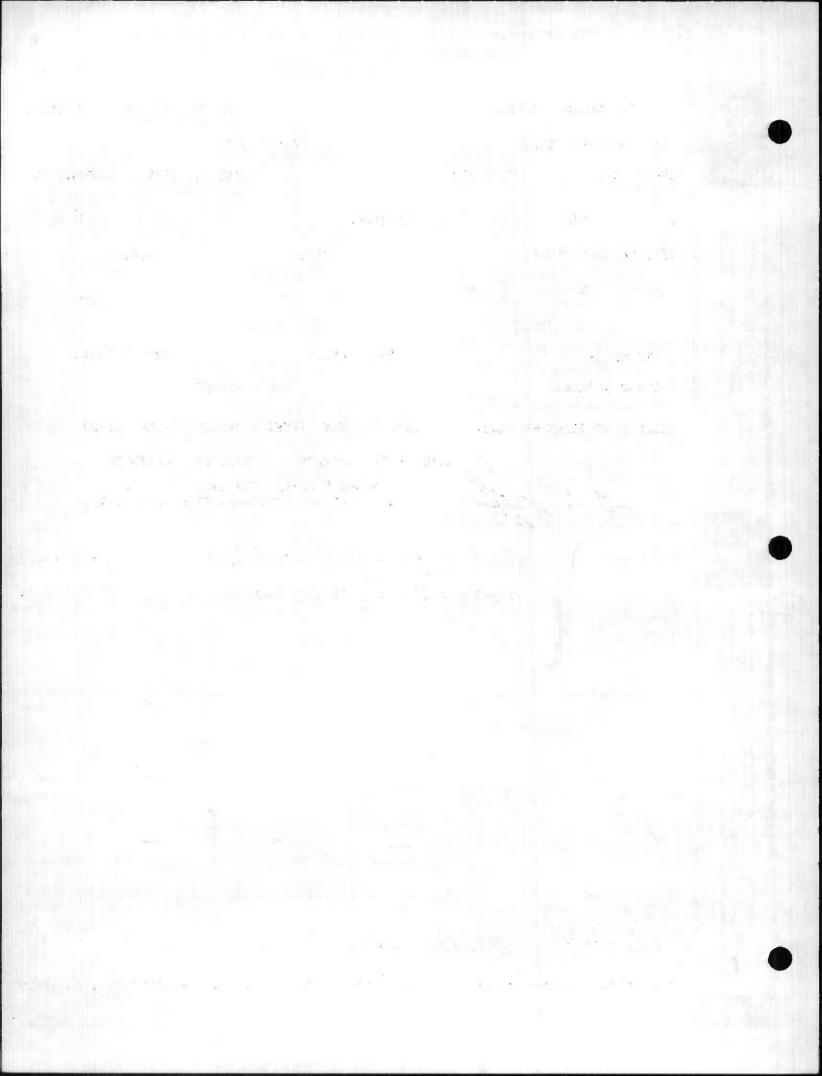


30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

1 🖳 Certifying Phyalcian: To tha best of my knowledga, daath occurred et tha tima, data and placa, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the causa(s) and manner stated.

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** 26 IANA UNKNOWN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) BALTIMORE

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Mpnth, Dey, Year) NIA 2242 ω . LEXINGTON If Under Months 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax **Funeral** 1 M 2 T Days 41 86011 Director 212 5/07/1956 MARYLAND Usuat Residence of Decedant with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 7 is marked other than "natural", or flams 23s or 28s-f shot treumstic event, the Moulcal Examiner must be notified at Bastimone 1 1 Yes 2 No M Director 10f. Zip Coda 10e. Sfreet and Number 10g. Citizen of What Country? Lexington Street 224210. 21223 USA M Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marifal Status Black, Whita, etc. 1 Never Married 2 Married Specify: Black DIANA TOWNE 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) FMPLOYEO N 18. Mother's Name (First, Middle, Meiden Sumeme) NEVER 17. Father's Name (First, Middle, Last) Be ROBINSON WILLIAM OWNES EASTER 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health I 2242 W. LEXINGTON ST. BALTIMORE, Mp. 21223

aca of Disposition (Name of Date 20c. Location - City or Town, State MOTHER) EASTER TOWNES Important: If item any injury or othe 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathed of Disposition 1 Burial 2 Cremation 3 Removal from State NEW CATHEDRAL CEMETERY4-01-98 BALTIHORE, MARYLAND 5 Other (Specify) 4 Donation 21. Signature of Fundral Service Lice 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arke shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Lapination disease or condition resulting in death) neu monia Examiner Examiner Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) signed by the a Part It. Other eignificant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 2 No Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Hydro Cepha hus Is certificate has director, page 2 1 ☐ Yes 2 ☐ No 1 Yas 2 No ai or Attending Physician: The safter death.

Ni Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Amesidenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Mannar of Daath 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 DNatural 5 Panding 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streef, factory, offica building, atc. (Specify) 4 Homicida In 24 hour.
The Funeral Direction of filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the Hospi within 24 hou To the Funer completely file 29a. Cartifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartiful 29c. License number Heyma a struck

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State Registrar 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print),

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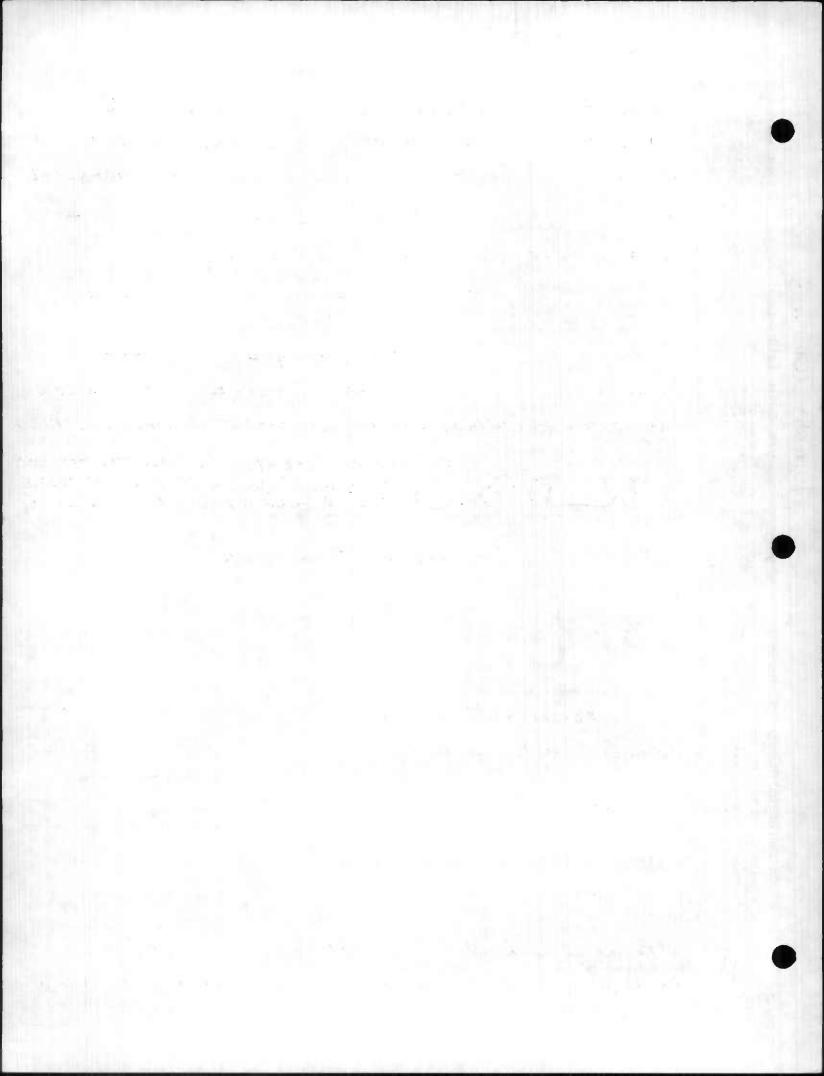
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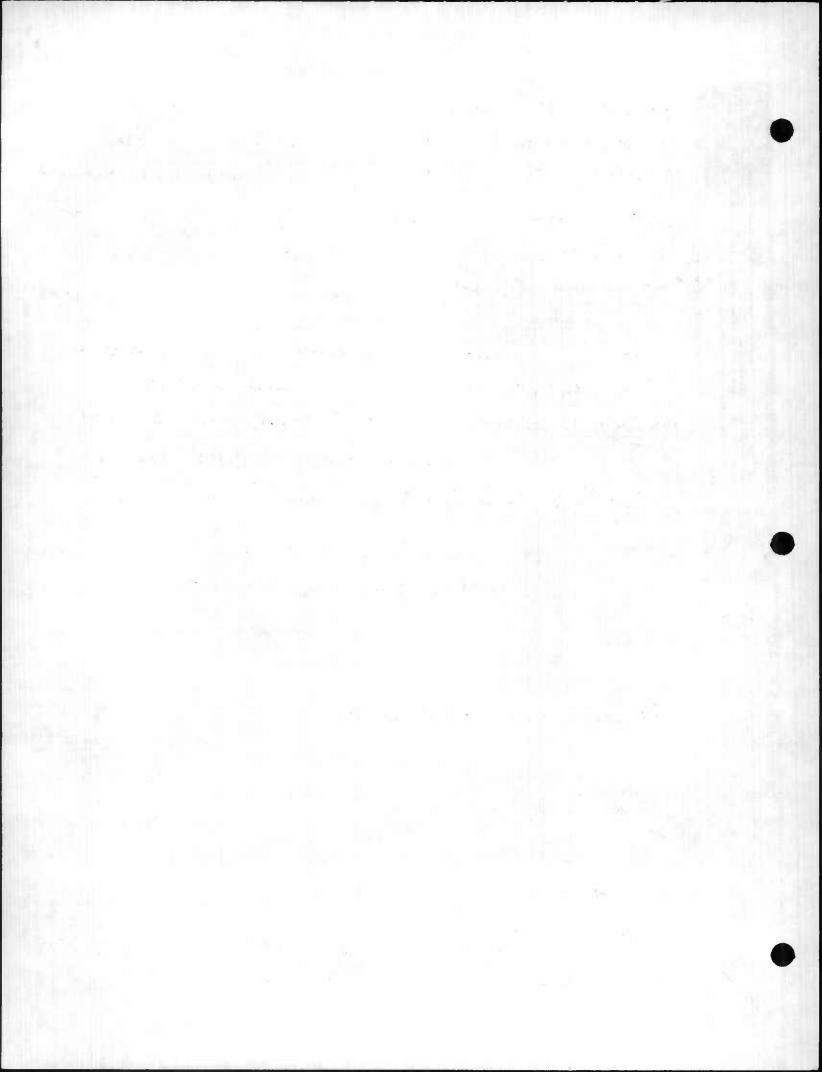
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urity Number - 506 \ nce of Decedent	6. Sex	7. Aga (In yrs			13641-1	a VVV DVC D		1	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death WARFIELD MARY 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3517 Orchard Avenue Baltimore 8. Date of Birth Month Day, Year) JAN 02, 1927 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days Hours Maryland 1 ■ M 2 🖫 F 213-22-4807 71 Yrs. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 Orchard Avenue 21244 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give A Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Intake Officer Juvenile Services 18. Mother's Name (First, Middle, Melden Sumeme) 17. Father's Name (First, Middle, Last) Lawrence Bates Russell, Jr. Ruth Rebecca Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21244 Harry L. Warfield/husband 3517 Orchard Avenue 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 XCremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 04/02/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) uneral Service License Cremation Society of Maryland, Inc. Edward A. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death RIGHT VENTRICUAR FALLRE Immediate Cause (Finel disease or condition resulting in death) PUMONARY TYPERTENSION Due to (or es a consequence of): SCIETIONETHA Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed?

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the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or hems 23a or 28a-f show any Injury or other traumatic event, the Medical Expirition must be not fluid and once.

Maryland 21215-0020

Baltimore,

Division of Vital Records, P.O. Box 682

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest edical Physician/M

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

completion of cause of death?

AL No

25. Was cese referred to medicel examiner? 1 Yes No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b Time of 28c. Injury et Work? 28a. Date of Injury (Month, Day Year)

26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mannar as stated.

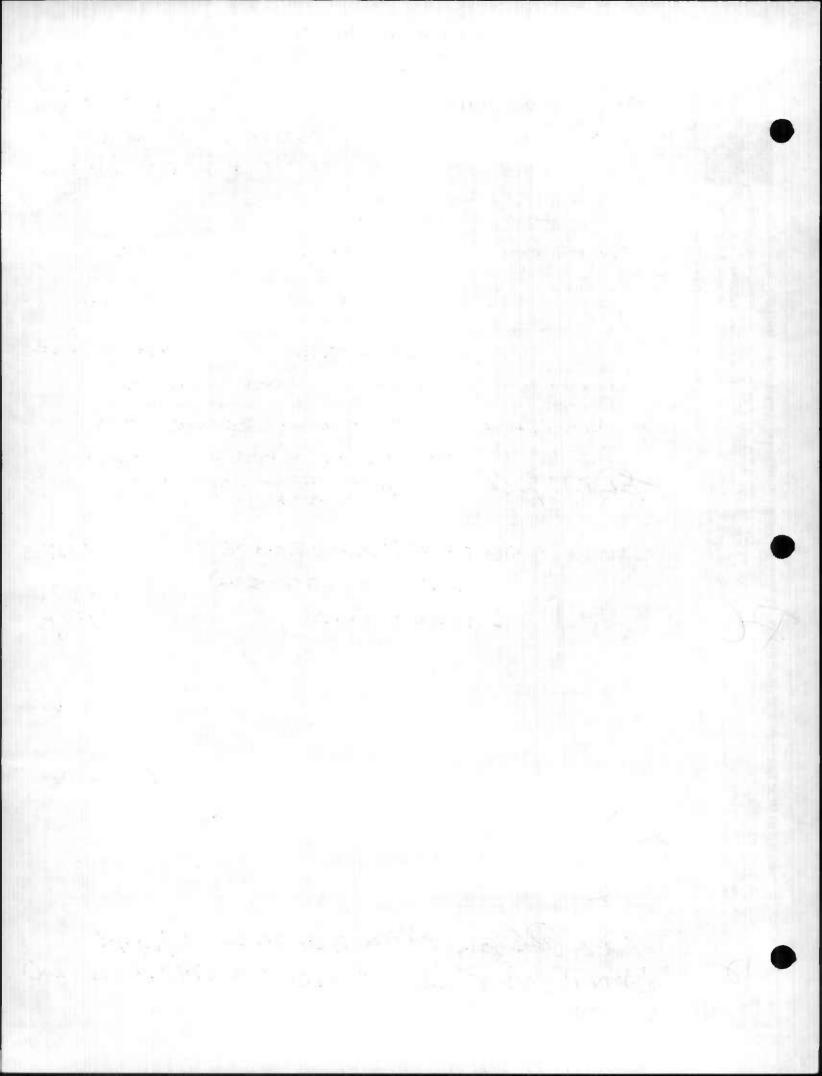
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

State Registrar

31. Dete fited (Month)

who completed ceuse of death (Item 23a) (Type, Print) CAMNE, WILLIES (THOE MD, BATTMONE, MD) 82. Registrar's Signature



32. Hogistrar's Eignature

31. Date filed (Mont

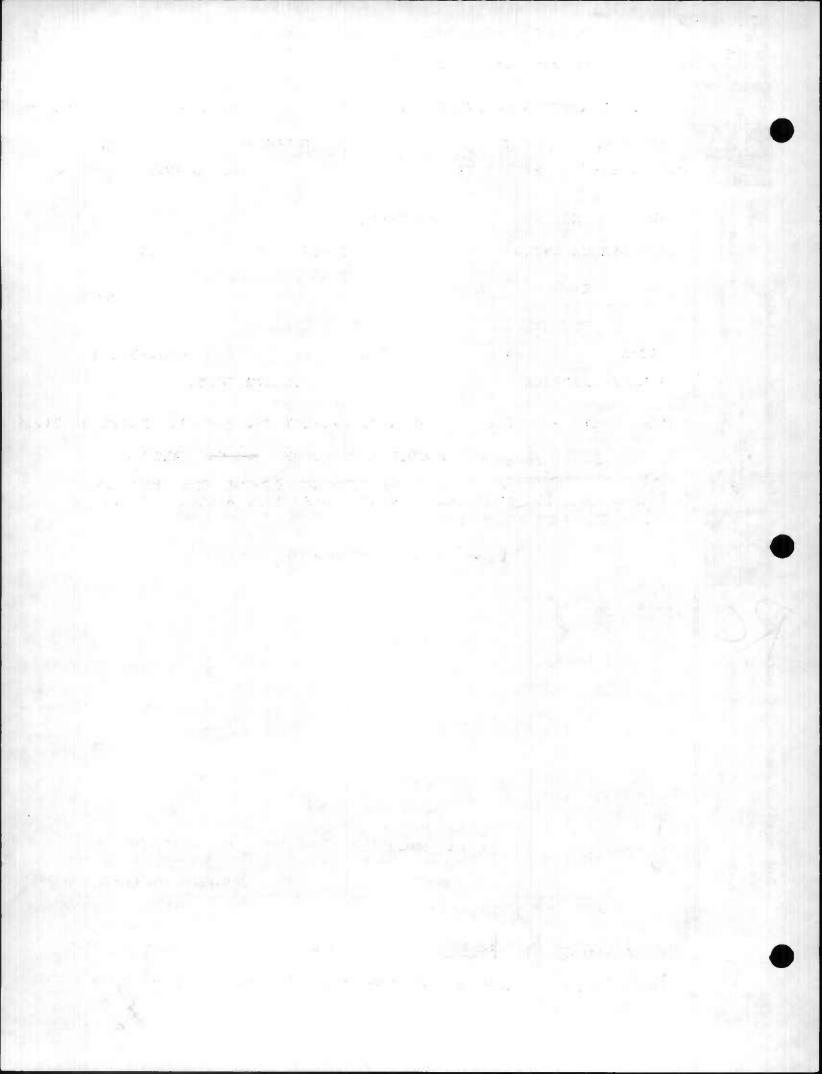
State Registrar

DHMH 16 Rev 6/95

22:28 PM

Funeral Director	5. Social Sacurity Numbe 213-02-308		7. Age (In yrs. las	t birthday) Yrs.	Months Days		Min. 8. Date of I	Pay. Year. 1976	9. Birthplace (State or Foreign Country) MD
faryland show ad et		dent County NA		Town or Lo					10d. Inside City Limits 1,
) Iter death with the Marylar Iter death with the Marylar Item 23a or 28a-f show Item 23a or 28a-f show Item 23a or 28a-f show	10e. Street and Number 2459 SEAM	ON AVENUE			10f. Zip Code 212	25		10g. Citizen of USA	What Country?
Remail Remail		Armed 1 7 Yea	Decedent Evar In U,S. I Forces? es 20 No Give		Was Decedent of f Yes, specify Cul		n? (Specify Yes or Puerto Rican, etc.)	Bla	ce - American Indian, ck, White, etc.
72 hour natural occur	15. [Decedent's Education by highest grada complete	or Dates:	(Give	lent's Usual Occu kind of work done	during most	of working	16b. Kind of B	usiness/Industry
	Elementary/Secondary	NA	e (1-4or 5+)		COOK		- N	RESTA	
Iryland 2 hould be filed and Mental Hygi marked other matic event,	ROBERT W						s Name (First, Midd RON SMIT		ne)
C - OI L	19a. fnformant's Name/F SHARON SMI			2034	N. CAL		or Rural Route Nur ST. 2nd	fl. BA	LTO. MD 21218
Page:	20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5 X	n mation 3□Removal fr Other <i>(Specify)</i> MaUSO	om State cen	ODLAV	sition (Name of natory or other pl NN CEME	TERY	4-3-98 4-2-98	BALTO.	
Baltim parmit. Pa Departmen Important: any Injury once.	21. Signiture of Funeral	Servica Licensee	to hand				UNERAL HO		INC. 21215
by Section 1970, Box 50 Months that the death certifier he attending principle of the strength	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	Due to (or a	G: Na as a conseq as a conseq	juence of):				Onset and Death
ords, P.O. Box e equires that the death certificate signed by the attending touid be detached for use attend by Physician/Mexicia	Part II. Other significant	conditiona contributing t	o death but not rasult	ing in the u	nderlying cause g	iven in Part I.			ontribute to the cause of death
ecords, aw requires th as been signe 2 should be of								es en eutopsy erformed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec	of Westernalis							e Yes 2□No	15 4es 2□ No
Of Vita Physicism: this certific rel director,	25. Was case relerred to examiner?	Hospital:	☐ Inpatient 2,☐ E	R/Outpatier	nt 3 DOA	thar:	of Death (Check on sing Home 5 R		her (Specify)
Division of Vital Recomplete the Hospital of Attending Physician: The law ray the Funeral Director: After this certificate has been prepared in by the funeral director, paga 2 standed cardical Certification: To Be Complete	27. Manner of Death 1 Neturel 5 [2 Accident	28a. D	ete of Injury Month, Day Year)	8b. Time of fnjury	28c. Inj		28d. Dascril	oe how injury occu	irred
Division of the function of th	3 ☐ Suicide 6 ☐ 4 ☑ Homicide	Could not be determined 28e. P	lacs of Injury - At homulading, etc. (Specify)	_	eet, factory, office	Ð	28f. Location City or 2011-11	n (Street and Num Town, State)	Boundle Number,
Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi			the best of my knowled basis of examination	edge, deeth on and/or in	n occurred at the vestigation, in my	time, date and opinion, deati	place, end due to t	he cause(s) and n	
To the within To the comp		f cartifier	i.	,	29c. Lice	nse number		29d. Date sign	ed (Month, Day, Year)
	30. Neme and address of	berson who completed	Cause of deeth (Item 2	23a) (Tvpe	OC.	ME		MARCH	29, 1998

111 Penn Street, Baltimore, Maryland 21201



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

The HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

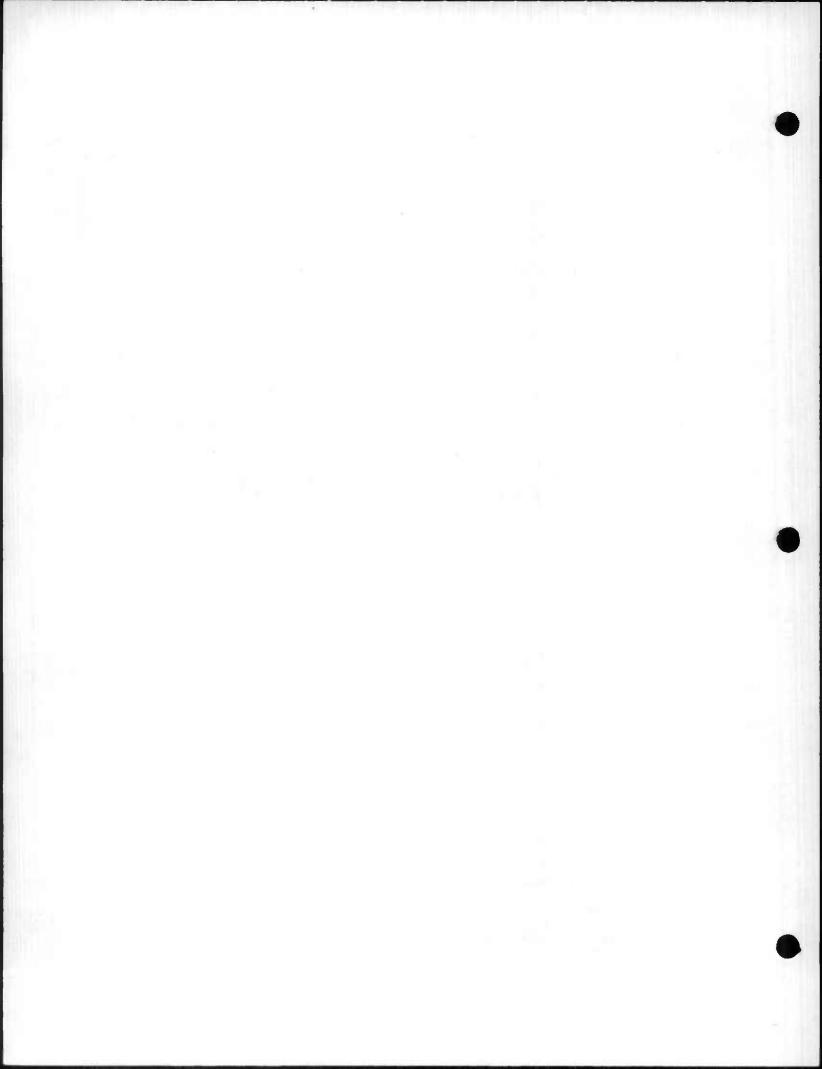
The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

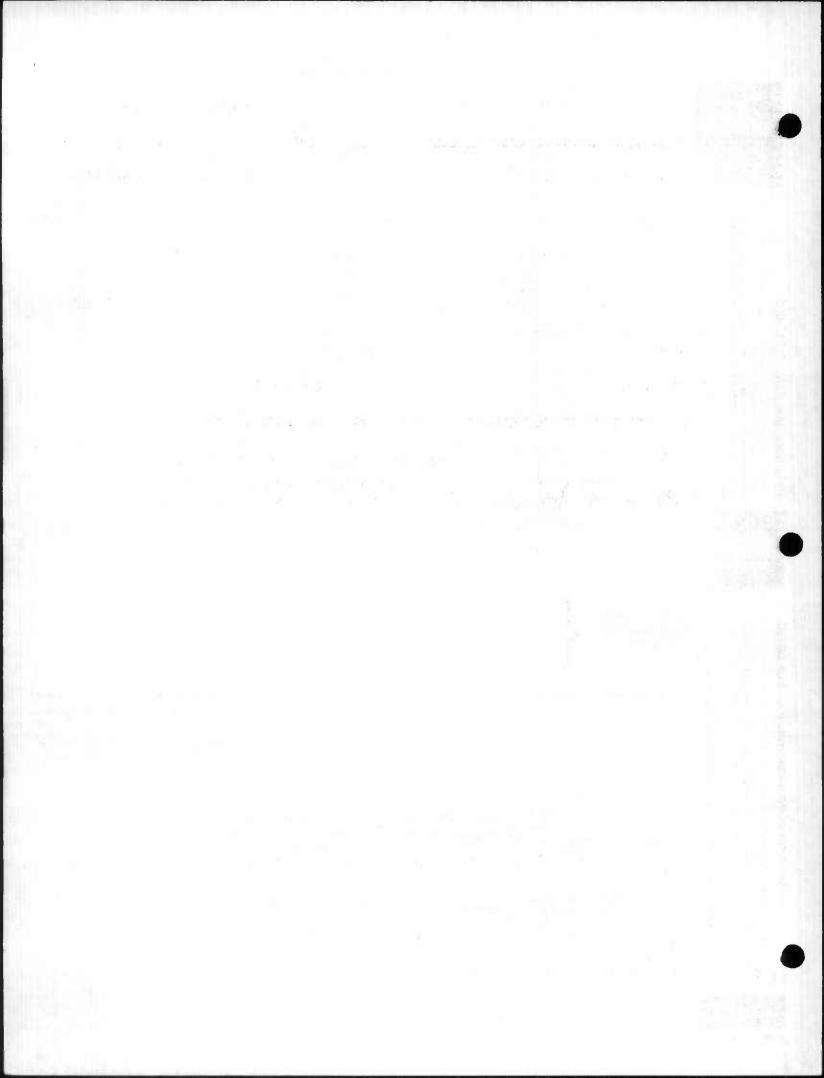
STATE	0F	MARYLAND	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	0	F DEAT	ГН		REG. NO.

1	FOR STATE REGISTRAR		STATE OF M				HEALTH AND	MENTA	L HYGIENE REG. NO.			
1	1. OECEDENT'S NAME (First, Middle)	le, Last)	41	ATKIN	5			2. DATE MONT	OF OEATH DAY	9 1998	IR.	TIME OF GEATH
	3.13-01-86	9/ 1	M 2 F	6. AGE (In yrs. le		IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	(Mont	OF BIRTH h, Dey, Year)	7 0	ountry)	MD ,
	9a. FACILITY NAME (If not institution CICH MEAD RESIDENCE OF DECEDE	XUS	N. H.			Glen	ARM ARM	EATH //	D.	BA.	HI)	nore)
		COUNTY	IMORE			TOWN OR LO						d. INSIDE CITY LIMITS? TYES 2 X NO
	104. STREET AND NUMBER	ARM R	OAD				21057			10g. CITIZEN		T COUNTRY?
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	ed	FORCES? 1. IF YES, GIVE W	YES 2		If yes,	ECENDENT OF HISPA specify Cuban, Mexico ES 2 NO Specific	en, Puerto		or No- 14. F	RACE — Black, W Specify:	American Indian, hite, etc.
	15. OECEDEN (Specify only high: Elementary/Secondary (0-12)	T'S EDUCAT	ION		'Give kind of w fe. Do NOT use	retired.)	TION most of working	161	b. KIND OF BUS			
	12th GRADE	(ant)		A	.CCOUN	I'AN'I'	18. MOTHER'S NA	ME /Elmt	MARTIN		I'I'A	
1	FRANK HEMING		KINC									
	19a. INFORMANT'S NAME (Type/Pr		VTIAO	Ti	96. MAILING	ADDRESS (Stre	St and Number or Rural		AUSTIN		p)	
	MARGARET WATK						ARM ROAD				057	
	20a. METHOD OF DISPOSITION		CALIFORNIA CONTRACTOR	20b. PLAC	E OF DISPOS		cemetery, crematory or	النايدات		ATION — City		State
	1½ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		I from State	MORE		MEMORT	AL PARK		HTT.	LENDAL	E. I	4D
1	21, SIGNATURE OF FUNERAL SEP	WICE LICEN	SEE /			22. NAME	AND ADDRESS OF F					
1	N/ leath	11	A line				NSON FUNE L LOCH RA					21286
	shock, or heert immediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a	A S OUE TO O		EQUENCE OF): 	1emm Demon	on, tin	Î A			Interval Between Onset and Death A Years
	PART II. Other algnificent co	onditiona	contributing to	deeth but not	t resulting i	n the underl	ring cause given in	Part I.	24s. WAS AN PERFOR	MED?	CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
ı												
	25. WAS CASE REFERRED TO ME EXAMINER?		IOSPITAL:		1	QTHER:	PLACE OF DEATH (C	heck only o	one)			
	1 TYES 2 TONO		☐ Inpetient 2 ☐			Aursing I	lome 5 - Residence	1				
	27. MANNER OF DEATH 1 Natural 5 Pend		28a. DATE OF (Month, Da	INJURY ny, Ybar)	28b, TIM	URY	INJURY AT WORK?	28d. DE	SCRIBE HOW IF	JURY OCCURE	.D	
	3 Suicide 6 Could	tigation d not be mined	28e. PLACE Of building,	F INJURY — At I	home, farm, s	street, factory, o	ffica	261. LO Ch	CATION (Street a y or Town, State)	nd Number or R	ural Rout	te Number,
	Cornick Orny						late and place, and du				use(a) a	nd menner as stated.
	29b. SIGNATURE AND TITLE OF	She	my K	les	an	D	DOS		^	≥ M	aned (M	ch 30, 1998
	W.A. K	SON WHO	4 6	B M		Print)	N. Cha	les	St.	BAG	6.	ch 30,1998 Md 2120
	31. DATE FILED (Month, Day, Year) ΔPR 0 2 1998		Julia Dev	R'S SIGNATURE	dalle							

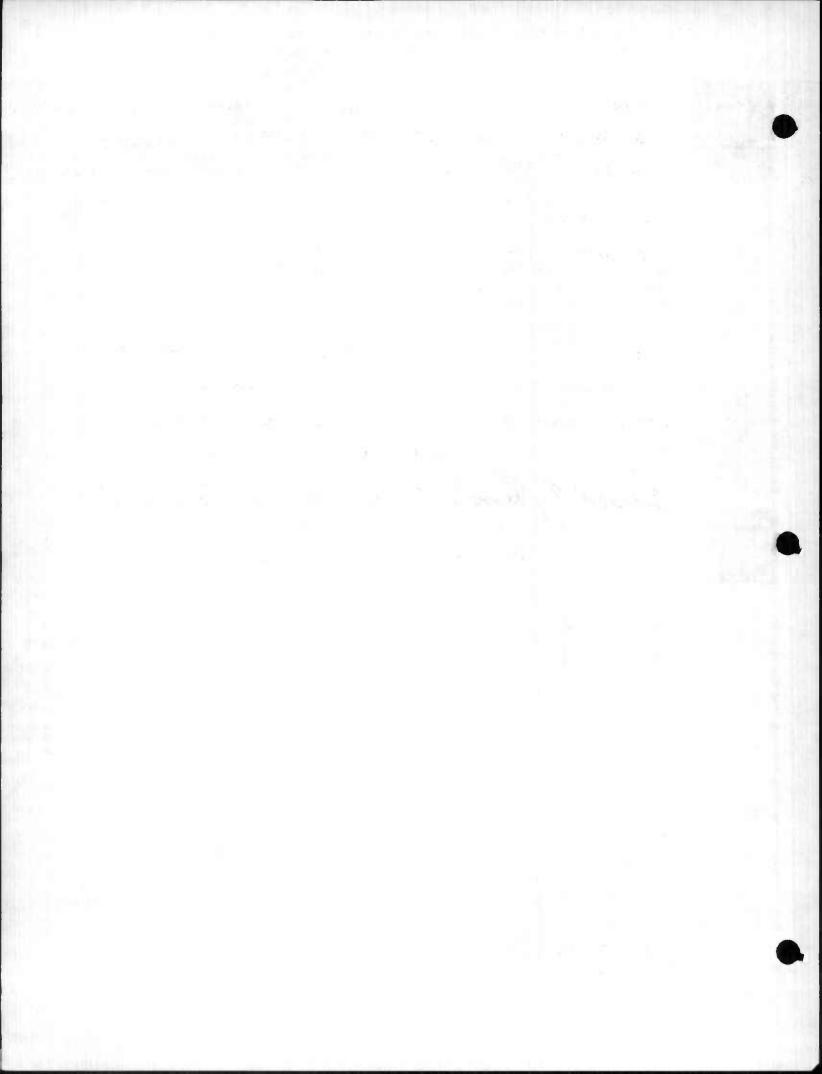


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Lest) 2. Data of Death 3. Time of Death **Physician** Month 1998 3:30 AM WOODEN MARCH 27, GEORGE J. /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALTIMORE CO. HERITAGE NURSING CENTER GERMAN HILL DUNDALK If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, 6-3-24 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpiace (Stata or Foreign Funeral 1₩ 2□F MARY LAND 73 Director 218-18-3224 Usual Rasidence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydene.
Important: If them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Madical Express must be notified at once. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No Director BALTO. CO. DUNDALK MARYLAND 10e, Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2003 BARRY ROAD 21222 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 □ Yas 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) 8 YEARS College (1-4or 5+) LONGSHOREMAN ILA 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be UNKNOWN UNKNOWN 20 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) MRS. CHRISTINE KOKOSINSKI 2003 BARRY RD. BALTO. MD. 21222 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriei 2 □ Cramation 3 □ Ramoval from Stata GARRISON FOREST VA. CEM3-30 BALTO. CO. MD. 4 ☐ Donetion 5 ☐ Othar (Specify) KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Setween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) MEASTATIC LANCER OF LUNG /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be asso-Box 68760, attending physician for use as the buria Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed by 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? this confilicate for Attending Physician: after death. Director: After this carifica Be 25. Was case referred termedical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 210 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? TypiNatural 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 ☐ Could not be 28i. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral C 1 Certifying Physician: To the best of my knowladga, daath occurred at tha time, data and place, end dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signeture, and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause oi daath (Itam 23a) (Type, Print) 6 2 Merler 32. Registrar's Signatura 31. Dete filad (Month, Day, Year) State APR 02 1998 ia Davidson Registrar



		Li Dandari Nana (Fina Aria)	State of Mary		tificate of		F	Reg. No.	10	410
Physi /Med		1. Decedent's Name (First, Middle, Las HETTIE	Ε.	AY	DELOTTE		2. Date of Dea Month MARCH	Day 13	Year 1998	3. Time of Death 8:00 A.M
Exam Funera Directo		4a. Facility Name (If not institution, give SARA MARGARET 6. Social Security Number 6. Security Number 11.	and MOLLY, A	ASSIST. I yrs. last birthday) Yrs.	IVING If Under 1 Year Months Deys			W]	9. Birthplac	O ca (State or Foreign AWARE
eryland ahow		Usual Residence of Decedent 10a. State 10b. County		: City, Town or Lo					10d	I. Inside City Limits
ath with the Merylan 23s or 28s-f show	i Director	MD. WICOM 10e. Street end Number 36336 REGINAULT		WILLARI	10f. Zip Code	1874		10g. Citizen of \	What Country	Y Yes 2 No
items items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:			Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Dican, etc.)		ce - American ck, White, etc	c.
y within jene. r than "	Completed	15. Decedent's Edi (Specify only highest grad Elementery/Secondary (0-12)	cation le com <i>pleted)</i> Coilege (1-4or 5+)	//fe. L	lent's Usual Occu kind of work done OO NOT use retire	•	king	16b. Kind of B	usiness/indus	
should be filed nd Mental Hygid marked other umetic event, the	To Be C	17. Fether's Name (First, Middle, Last) WILLIAM	WEBB			18. Mother's Nem		Malden Sumen KINS	ne)	
s 1 an of Heel Item 2 other		19e. Informant's Name/Reletionship (7) JOY WILKERSON-DA 20e. Method of Disposition 1 № Buriai 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)	UGHTER 20 Removal from State	902 b. Plece of Dispo- cametery, crem	LOCH RA				2180 City or Town	04 n, State
permit. Pages 1 at Department of Hee Important: If Item: any Injury or othe		21. Signatured Funeral Service Licans	-	22	. Name end Addr		70.	5 E. MA	IN ST.	
death certificate be executed the properties of the burlan from the properties of the burlan from the properties of the	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. CAN Due l		uence of):				In	pproximate iterval Between onset end Death
ss that the d gned by the be detached	d by Physician/M	Pert II. Other aignificant conditions con	ntributing to death but not	resulting in the ur	nderlying cause gi	iven in Part I.	101	/es 2☑ No	3 □ Probat	bly 4 Unknown
a law has b	Completed					J	24a. Was e perfor	med?	evaila	able prior to pletion of cause ath?
ding Physician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manpar of Deeth 1 Netural 5 Pending investigation	fospital: 1 Inpatient 28a. Date of Injury (Month, Dey Yea	2 ER/Outpatien 28b. Time of Injury	28c. Inju			ne) ence 6 Oth	er (Specify)	
ital or Attendus after death	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp.		eet, factory, office		28f. Location (S City or Tow		er or Rural R	toute Number,
To the Hospital of within 24 hours a To the Funeral D completely filled it	Medical	one) 2 Madical Exami	ner: On the best of my ner: On the basis of exam end manner stated.	knowledge, death nination and/or inv	estigation, in my	opinion, death occur	red et the time, o	late and placa,	and due to th	e cause(s)
Vit To To		29b. Signature and title of cartifier 30. Neme and address of person who co	JUL mpleted ceuse of death (Item 23e) (Type. I	29c. Licen	1871		3/13/	90	y, Year)
C	5 tate	Sco Rivering 101 31. Date filed (Month, Day, Year) MAR 1 6 199	32 Registrar's Si	404	A S	alis bu	ly m	702	1801	



State of Maryland / Department of Health and Mental Hygieneg

						Cer	rtificat	e of	Death			Reg. No.	20	1 (7 4 1	-
	Physic /Medi		Decedant's Neme (First, Middle Willis Ellsworth Be								2. Deta of Do Month March			Yaar 1998		of Deeth
	Exami		4a. Fecility Neme (If not institution Frostburg Village		r)				Frostbu	ırg	cation of Dea	th 4c.		of Deeth egany		
	Funeral Director		5. Social Sacurity Number 216-20-0290	6. Sex 1 □ X	Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Bi (Month, D 15-Jan	rth ey, Year) -24		9. Birthpl Count Maryl	try)	a or Foraign
	ter death with the Maryland Hems 23a or 28a-f show	Director		egany	10c. City, To									10		City Limits
	th with th		10e. Street end Number 13806	Oleander Driv	ve		10f. Zip	215	02-				J.S.A.	What Count	try?	
020	el', or	by Funeral	11. Marital Status 1 □ Never Merried 2 M Merri 3 □ Widowed 4 □ Divorced	12. Wes Deceder Armed Forces ed 1 1 1 Yes 2 If Yes, Give Yeer or Dates	S?] No		Was Daced f Yes, spec l□ Yes				city Yes or Na Rican, atc.)	0-	Bled	e - America ck, White, e	etc.	· E
1215-0	d within 72 hours plena. r than "naturel", the Medical Ext	Completed	15. Decedent (Specify only highes Elementery/Secondery (0-12)	's Education t grede completed) College (1-40	r 5+)	Sa. Deced (Give lifa. L		ol Occu rk done sa ratire	pation during mos ed)	at of workin	ng		nd of Bu	usiness/Ind	lustry	
Maryland 21215-0020	should be filed and Mental Hygis marked other matic event,	To Be Co	17. Fether's Name (First, Middla, I Courtney Beckmo	Last)						er's Neme	(First, Middle					
	d 2 sh th and 7 is m treum		19e. Informent's Name/Reletionsh Anna Mae Beckmo				ng Address eander				Route Numberland		r Town, Maryl		Code) 21502	2-
altimore,	8 = 5		20e. Method of Disposition 1 Burial 2 □ Cremetion 4 □ Donetion 5 □ Other (Sp	pecify)	e Philos C	tery, cren cemete	netory or o	ther ple		1	Mar-98			City or Tov		
Bal	pemit. Pa Departmer important: any injury once.		21. Signeture of Funeral Service I	Dury	1				ess of Fecili I Home		ost Ave.	Frostl	burg,	MD 2	1532	
	Physician /Medical Examiner	ner	23a Pen1: Enter the disease, or shock, or heert feilure. List of the control of t		Due to (or es	my	O CA						01		Intervel E Onsat an	nd Death
ox 68760,	eath certificate be axecuted attending physician and for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest	c	Due to (or es											
.O. Bo	0 0 0	Physician	Pert II. Other algnificant condition					ause g	iven in Pert	l.		tobacco		ntribute to		e of death?
rds, P	sign d be	by	HYPE	FIRACTENSIO	W.	L	INC	7	MA	55	24e. We	s an eutopormed?		24b. We		sy findings
of Vital Records,	has the	Completed	MULT	RTENSIO INFAI	RCTION	Z	EH	En	MIL	7			No	of d	npletion of seath?	
Vita	letan: certific rector,	Be	25. Wes case referred to medical exeminer?	Hospital:				0	26. Plece	e of Deeth	(Check only					
	는 부글	ation: To	1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending investig	ation	iury 28t	o. Time of Injury		8c. Inju		2	ne 5 Res 8d. Describe				")	
Division		Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Pleca of I	njury - At home, etc. (Specify)						8f. Location City or To	wn, Stete)			lum <i>ber</i> ,
	To the Hospital or within 24 hours after To the Funeral Dir complately filled in	edical	29e. Certifier 1 Certifying (Check only one) 2 Medical E	Phyeician: To the bes examiner: On the basis and menner	mination (ge, deeth end/or inv	occurred of occurred of occurred of occurred of occurred of occurred of occurred of occurred of occurred of occurred of occurred	et the t in my	ime, date er opini <i>on</i> , dee	d pleca, e th occurre	nd due to the d at the time	ceuse(s) dete end	end me d pleca,	enner es ste and due to	eted. the caus	a(s)
	14	M	29b. Signeture and title of cartifier	Nymo	En	n	290	Licen	se number	95				d (Month, L		•
+	1 VA m5s		30. Nama and eddress of person v Chang-Hyun Oh,	who completed cause of MyD., 57 Tarn	deeth (Item 23e	o) (Type, I rostbu	Print) Urg, Mo	arylo	ınd 215	32						
	Sta Registi		31. Dete filed (Month, Dey, Year)	1998 32. Regis	trar's Signature	Bro	latt									

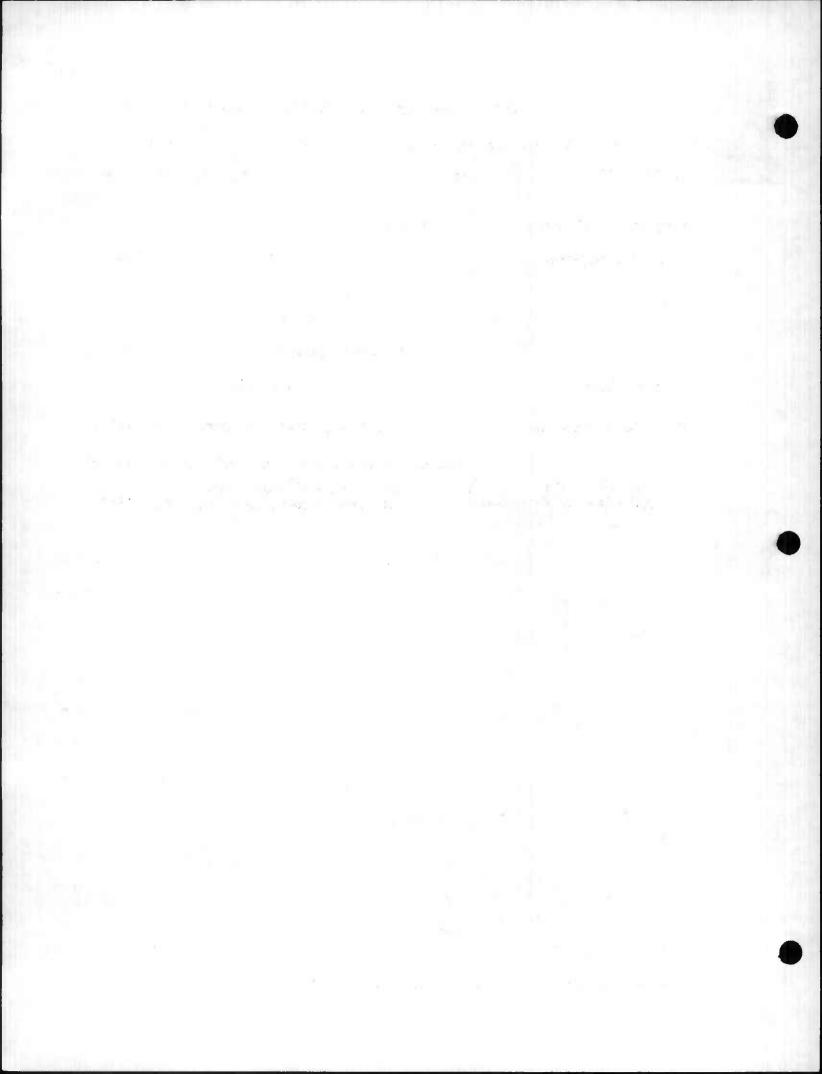
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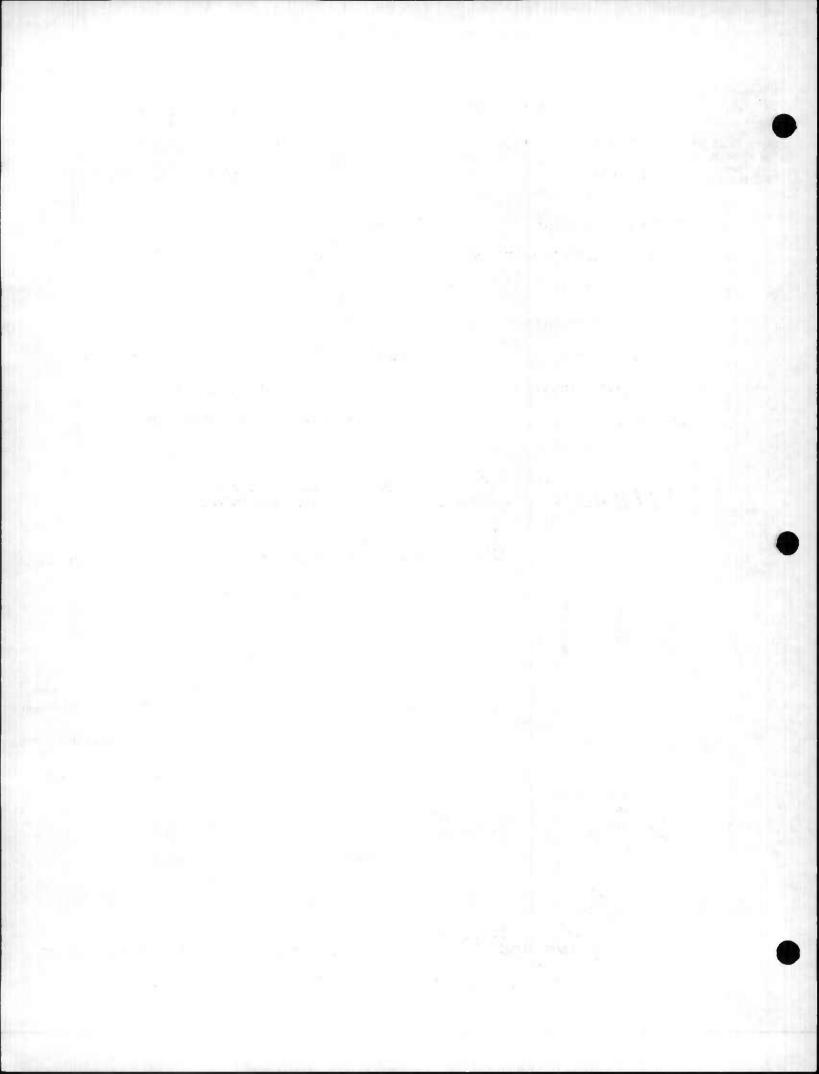
State of Maryland / Department of Health and Mental Hygiene

			Otate of Iviary				Death		Reg. No.	3	0412
Physic /Medi		Decedent's Name (First, Middle, Last	EDNA	LUCILLE		BROAD	WATER	2. Dete of Dea Month March	Day	Year 998	3. Time of Dear 12:09
Exami		4a. Facility Name (If not institution, give	street and number)	20011111			4b. City, Town, or I		7		
		Memorial Hospita	l & Medica	l Center	•		Cumber		Alle	gany	
Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthda	y) If Uni	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	(Month, Da)	, Year)	9. Birthpla Country	ce (State or For
Director		207-32-2536	74	1 Yrs.				June 12	, 1923	Penns	ylvania
/land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or I	Location					100	d. Inside City Lin
Man a-f al	ş	Maryland Allega	ny	Fros	tbur	7					1 □ Yes 2 (2)
or 28	Director	10e. Street and Number	117	1100		Zip Code		10	10g. Citizen of V	Whet Country	y?
th wi		54 Armstrong Stree	t				21532		1	USA	
r dea	Funerai		12. Was Decedent Ever Armed Forces?	in U,S. 13	. Was De	cedent of h	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Rac	e - Americar k, White, et	
72 hours after death with the Maryland "netural", or frems 23s or 28s-f show soles! Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 【 Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:			2 K) No			Specify		
72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	edent's U	suel Occup	pation during most of wor d)	rking	16b. Kind of Bu	ısiness/Indu	stry
C 1 6	npie	Elementary/Secondary (0-12)	College (1-4or 5+)					King			
a filed withing Hygiene. other than	ပို	8		Wai	tres	s-Hom	emaker			taurar	ıt
d d d	Be	17. Father's Name (First, Middle, Last) Charles Clark						ne <i>(First, Middl</i> e, Deitle	Maiden Sumam	ie)	
id 2 should be file Ith and Mental Hy 7 is marked othe treumatic event.	To	19e. Informant's Name/Relationship (Ty	no Print)	10h Ma	ilina Addr	ana /Strant	and Number or Ru		r City or Tour	State Zin C	Parto I
and 2 sealth an n 27 is in treu						200					
a 1 and 2 should Health and Mer Tem 27 is merke other treumatic		Carol Lucas/Daught 20a. Method of Disposition	2	Ob. Place of Dist	position (/	Vame of	Street,	Date	20c. Location -	21532 City or Town	
8 = ± 8		Bunal 2 ☐ Cremation 3 ☐ F Donation 5 ☐ Other (Specify)		cemetery, cr				1000	Manna	-1	2.8
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License					March 26 ss of Facility	, 1998	weyersa	are, F	A
89 E 8		· A Lund	(10-10-)				eral Home				
- 59		23a. Part1. Enter the discount, or compleshock, or heart the time. List only or	cations that caused the	death. Do not e	OL G	rant lode of dyi	Street, S	Salisbur or respiratory ar	y, PA rest,	P	Approximete
Physician /Medical		Immediate Cause (Final	e cause on each line.							ä	nterval Between Onset and Death
Examiner			myocardia			-		-		3	days
	Je			to (or as e cons							
cuted nd rransi	Examiner	Sequentially list conditions,	coronary	to (or as a cons						- 8	years
ificate be exe g physician a as the bunal-i		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events									
rificate be executed of physician and as the burial-transit	edical	that initiated events resulting In death) Last		to (or as e conse	equence o	f):					
E 0 0	Me		l								
death cert e attendin	cian										
that the death cert ed by the attendin detached for use	Physician/M	Part II. Other aignificant conditions con	tributing to deeth but no	t resulting in the	underlyin	g cause giv	en in Part I.				ha ceuae of de
es that igned b	by Pi							וטו	es 2 No	3 Proba	ibly 4∭ Unkr
he law requires that the has been signed by th tge 2 should be detache								24a. Was		24b. Were	e autopsy findin- lable prior to
law re as bee	Completed							perfor	med?	comp	pletion of cause eath?
The law ate has page 2	EO							1 🗆 Y	es 2 No	10	Yes 2 No
ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?					26. Plece of Dee	eth (Check only o	ne)		
Physician: r this certific ral director,	0	1 Yes 2 No	ospital:	2 ☐ ER/Outpati	ent 3	DOA Oth	ner: 4□ Nursing H	lome 5 Resid	ence 6 Oth	er (Specify)	
ing P	on:	27. Manner of Death 1 KNatural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time Injury		28c. Inju		28d. Describe h	ow injury occur	red	
Attending ir death. sctor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	Ope Pleas of trium	At home form	M		Yes 2 □ No	28f. Location (S	treat and Numb	ar or Dum! I	Pouto Number
al or Attending s after death. ii Director: After ed in by the fune	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S		street, tact	ory, office		City or Tow	n, State)	er or Hurar r	TODIE MUNIDER,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	Iclan: To the best of my nar; On the basis of exa and manner stated:	knowledge, dea mination and/or i	ath occurre	ed at the til on, in my o	me, date and place opinion, death occu	, and due to the d rred at the time, d	ause(s) and ma late and place,	inner as stat and due to ti	ted. he cause(s)
o the	Mec	29b. Signature and title of certifier	and majmer states.		- 4	29c. Licens	se number		29d. Date signe	d (Month, Da	ay, Year)
1/0		1/1/	m/			ъз	6766		March	23	1998
		30. Name and eddress of person who co	mpleted cause of death	(Item 23a) (Type	a. Print)	<i>U</i>			narch	7	1330
This		Dr. Vik Poonai-92				ale.	MD 21502				
Sta	te	31. Date filed (Month, Day, Year) MAR 2 5 1996	32 Registrar's t			,					



State of Maryland / Department of Health and Mental Hygiene Q

						Cranoa	ate of	Death		Reg. No.		
Physici	ian	Decedent's Name (First, Middle	e, Last)						2. Date of [Month	Deeth Dey	Yeer 3	3. Time of Deeth
/Medi		WAYNE (CAHRLES BR	IDGES,	SR.				MARCH	21, 199		736 AM
Examir		4e. Fecility Neme (If not institution	, give street end num	iber)			4	lb. City, Town, or				
		SACRED HEAR?	r HOSPITAL					CUMBERLA	ND	ALLEGA	ANY	
Funeral Director		5. Sociel Security Number 215 38 9610	6. Sex 1 XM 2 ☐ F	7. Age (In yrs.	lest birthde Yrs.	Months	ler 1 Year s Deys	If Under 24 Hrs Hours Min.	(Month, I	Birth (Dey, Year) 19 1938	9. Birthplece Country) MARY L	e (Stete or Foreig AND
and will		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or	Location					10d	Inside City Limit
with the Maryland	ō	MADAYY AND A 7 - 11	24277		**************************************	2000						1 ☐ Yes 2 N
138 the	Director	MARYLAND ALLE(10e. Street end Number	JANY		FROST		ip Code			10g. Citizen of V	Albert Country	,
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nous after dean win the Maryland lurel', or fems 23e or 28a-1 show a Examiner must be not the Jal	by Funeral	1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	Armed Fore	ces? 2 □ No 1 9 5	5 -		2 XNo	ispenic Orlgin? (S in, Mexican, Puerl Specify:	o Rican, etc.)		ck, White, etc.	
yene. jene. r than "naturel", the Medical Ex	Completed	15. Decedent (Specify only highes	's Education		16e. Dec	cedent's Us	ual Occup	etion during most of wor	rkina	16b. Kind of B	usiness/Indust	lry
than the	ople	Elementary/Secondary (0-12)	College (1-	4or 5+)	life	DO NOT	use retired	()	King			
	ő	12			SH	IPPIN	G DEP	ARTMENT		TIRE H	BUILDIN	IG
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marked o	10	WAYMOND BRII	OGES					EVEI	YN ATK	INSON		
th end Mer 7 is marke traumatic		19a. Informent's Neme/Relationsh	nip (Type, Print)		19b. Me	eiling Addre	ss (Street	en <i>d N</i> um <i>ber</i> o <i>r R</i> u	<i>iral Route N</i> um	ber, City or Town,	State, Zip Co	de)
- N -		JUDY BRIDGES / V	VIFE .		109	26 SU	GAR R	.OW ROAD,	NW, FI	ROSTBURG,	MD 21	.532
item 2 item 2		20e. Method of Disposition			Plece of Dis	position (Naremetory or	eme of	e)	Dete	20c. Location -	City or Town,	Stete
nent of interior		1 ☐ Burlel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Sp		tate		T CEM			/23/08	ECKHART,	MD	
트랜증		21. Signature of Euneral Segrice (• • •	/	CKIIAK			ss of Fecility	1/23/30	ECKHART,	, rib	-
Depa impo any i		M. 1	Yn 1	6	a	OWERS	FUNE	RAL HOME	-			
		11 Encloy	111:30	swerz	U 6	0 W.	MAIN	ST., FRO	STBURG	, MD 2153		
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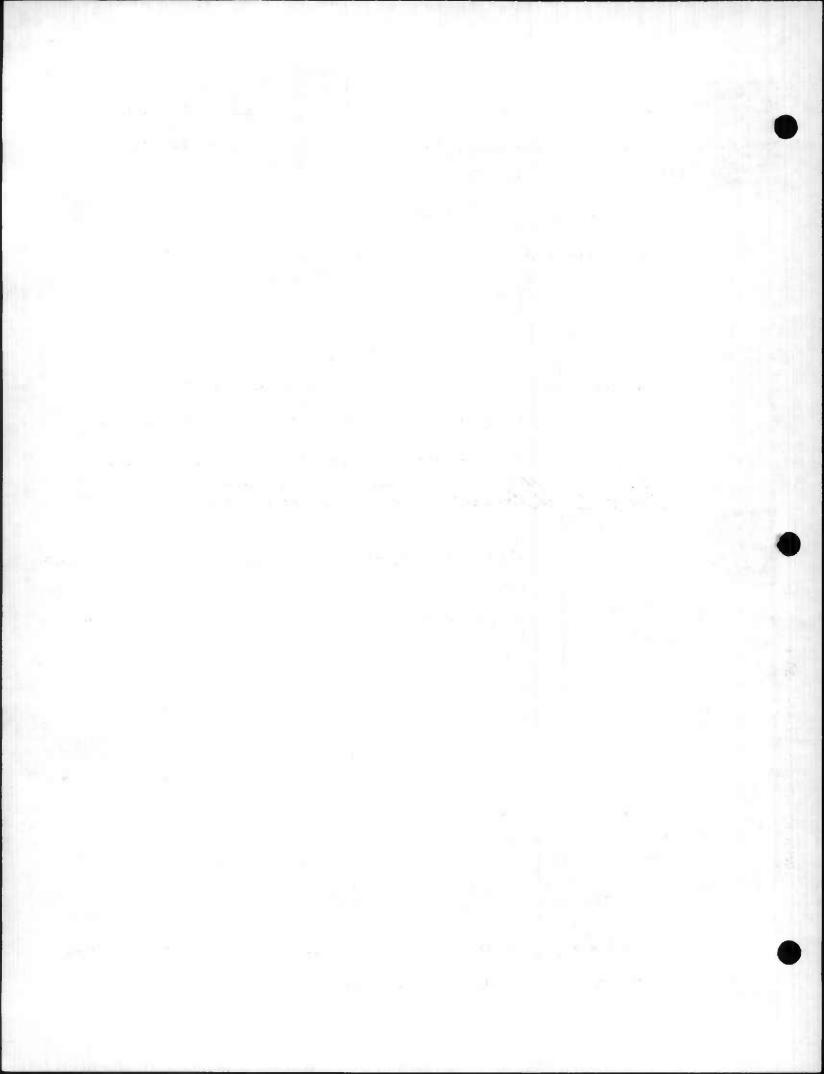


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Yaai **Physician** JOANN BROADWATER MARCH 21 1998 18:10 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ar If Under 24 Hrs. ALLEGANY 8. Date of Birth (Month, Day, Sept. 9 If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2□F Yrs. Director 214-48-3086 63 1934 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovenical Examiner must be notified at MD ALLEGANY CUMBERLAND XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11709 HOMEWOOD STREET NW 21502 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes ≥ ∑XNo If Yas, Give Yaar or Dates: Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter a neat of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or item any or other traumatic event, fire Medical Examinatory or other traumatic event, fire Medical Examinatory. 1 ☐ Never Married 257 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Spacify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH E. TWIGG HILDA BEAL TWIGG 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Broadwater Husband 11709 Homewood Street, NW Cumberland, Maryland 21502 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pege Department of important: If any Injury or once. Other (Specify) MD VETERANS CEMETERY Mar. 25, 1998 Cumberland, MD 22. Nama and Address of Facility
Merritt-Adams Funeral Home, P.A. 21. Signaturus Furfiral Service Licensee alu 404 Decatur Street, Cumberland, MD 21502 Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medicai Immediate Ceuse (Final adult respiratory distress syndrome diseese or condition resulting in death) 10 days Examiner Due to (or as a consequence of): Examiner coma 5 days ettending physician and for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): cor pulmonale BROADWATER 214-48-3086 of Vital Records, P.O. Box 68760, 10 years Physician/Medical Due to (or es e consequence of) cva 4 months been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of causa of deeth? hes e 2 page 1 Yes 2 No 1 ☐ Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred JOANN B 5 Pending investigation 1 Metural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide Medical 29a. Certifier 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Yaar) 29b. Signature and title of certifier 29c. License number 3 MD D44425 MARCH 23vd 1998 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) Trus DR. ANIL SINGH, 600 MEMORIAL AVE., CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Arrended #196, MAS Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible.

3/17/98, Bluggny County State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** 11, 1998 11:35 AM Ina Lee Burley Mar. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Friends Nursing Home Sandy Spring 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1 M 2 X Yrs. Director 216-22-7371 92 May 26, 1905 WV Usuei Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits ir than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Montgomery Brookeville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 19200 Mt. Airey RD 20833 USA Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) is marked other than 8 Own Home Homemaker Hygi 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be fit.
Department of Health and Mental th
important: if frem 27 is marked oth
any fujury or other traumatic even 89 2 William Crites Mary Elizabeth (Smith) 19e. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20 733 19200 Mt. Airey Rd., Brookeville, MD 21823 Ina B. Lyons 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Davis Memorial Cemetery 3/14 Cumberland, MD 22. Neme end Address of Fecility Kight Funeral Home 21. Signeture of Funerel Service Licenses 309-311 Decatur St., Cumberland, MD21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Onset and Deeth **Physician** Immediate Cause (Finei disease or condition resulting in deeth) /Medical Preumonia 5dAys Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed attending physician and for use es the bunal-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. detached 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown HATANKi <u>ک</u> 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peen Deep Van thombopklebitis has 1 ☐ Yes 20 No 1 ☐ Yes 2 No certificate il or Attending Physician: T safter death. i Director: After this certificat 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 21 No After this funeral dis 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Neturai 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide • Funeral Di-letely filled in Hospital edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. To the vithin 2 To the comple 29b. Signe and little of certifler 29c. License number 29d. Date signed (Month, Dey, Year)

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30. Nems and address of person who completed cause of death (Item 23a) (Type, Print)

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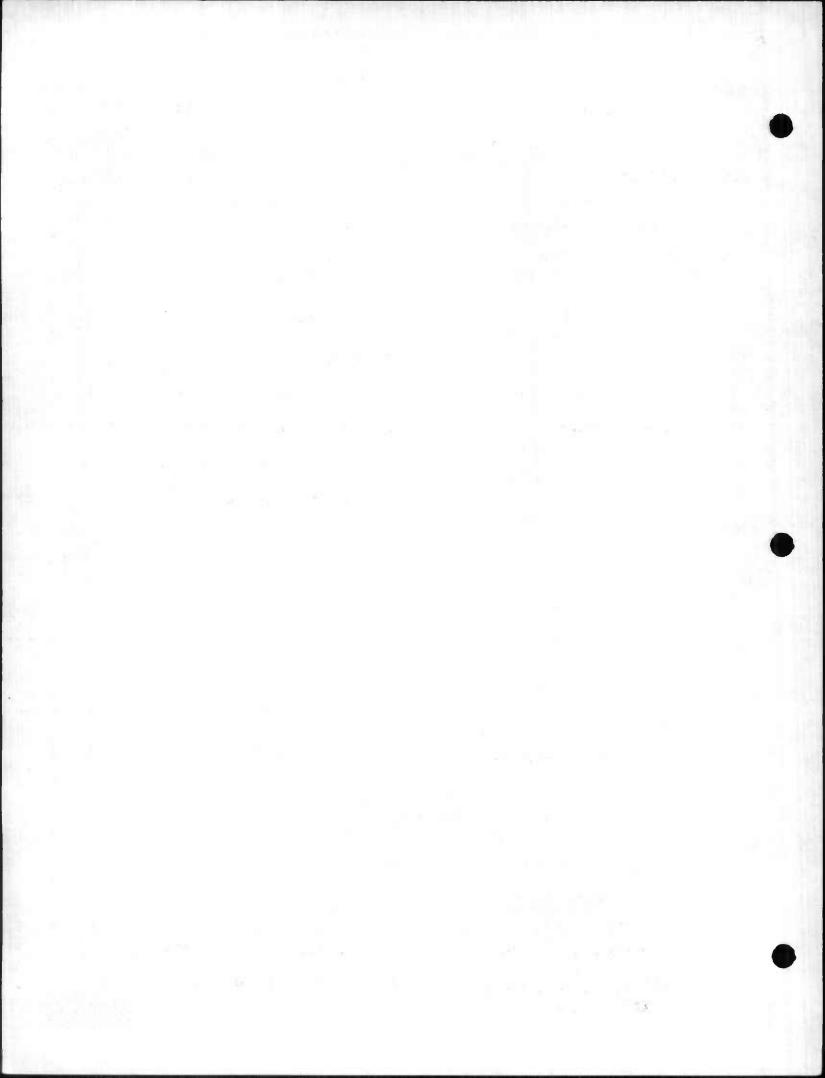
32. Registrar's Signature

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State Registrar

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THES



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month RUBY V. BANKS 13 1998 March 11:30 am 4a. Facility Neme (If not institution, give street end number) 4h City Town or Location of Deeth 4c. County of Deeth Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Deys Hours 1 M 2 F 92 Yrs. 214-74-3964 MD Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD WICOMICO SALISBURY 1 Yes X No 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 2618 SILOAM ROAD 21801 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) LOUIS TOWNSEND NAOMI TURNER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DONALD P. BANKS 107 GURNEY DRIVE, FRUITLAND, MD. 21826 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 N Buriel 2 □ Cremetion 3 □ Removel from State 5 Other (Specify) 4 Donetlon SILOAM CEMETERY 3/16/98 SILOAM, MD. 21. Signature of Funerel Service Licansee 22. Neme end Address of Fecility BOUNDS FUNERAL HOME, 705 E. MAIN ST., SALISBURY, MD Jaune unt. Enter the disease, or comme cetions thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, book, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) O.SIAJE con Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resuiting In deeth) Lest Due to (or es e consequenca of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Value 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evaileble prior to complation of cause of deeth? 24e. Wes en eutopsy performed? e RIOS eler DS12 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Examiner physician and the burial-transit the death certificate be executed Box 68760. esn ed by the a P.O. Records, has page 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Physician

/Medicai

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar death 1 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Nema 23, eny Injury or other traumatic event, the Mance

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Physician/Medical Certification: To

29a. Certifier

(Check only one)

4 Homicide

29b. Signeture end title of pertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Bahi)

29c. License number D02026

1XI Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner steted.

29d. Dete signed (Month, Dey, Year)

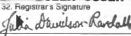
Federico G. Arthes, MD

1622A Ocean Pines

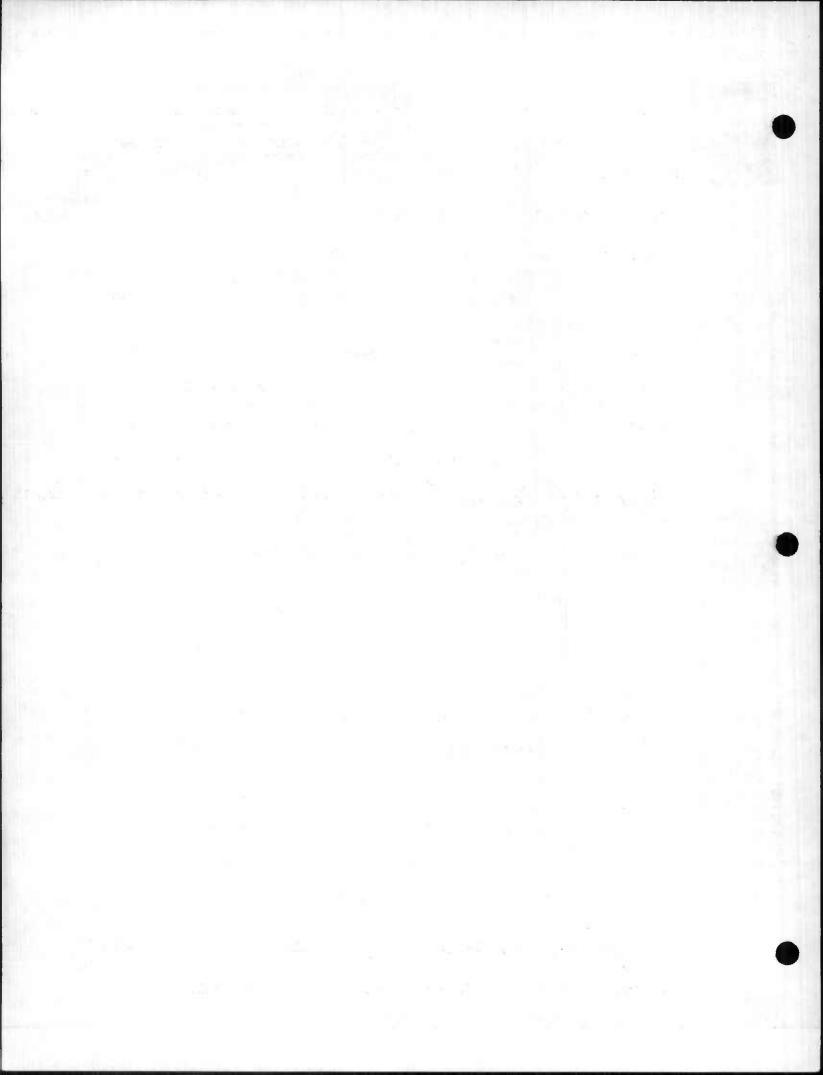
Berlin, Md 21811

State Registrar

MAR 1 6 1998



DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Counth Month **Physician** 03 BENTON 1625 EVELVN /Medical 4e. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** SALISBURY Under 24 Hrs. Hours Min. WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Birthplace (Stata or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□M 201F Director 220-18-6728A 90 12/03/1907 Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d, Insida City Limits 28a-f ahow tem 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic avant, the Maroical Examinar must be notified at 1 Yes 2 No Director Maryland Somerset Deal Island 10f. Zip Coda 10g. Citizen of What Country? 23183 Edelyn Webster Road 21821 USA Funeral 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, atc. Pages 1 and 2 should be filed within 72 hours after report of Health end Mental Hygiene. 1 Yas 2 If Yas, Giva Yeer or Detes: 1 Nevar Married 2 Married 2 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify. by 3 Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collaga (1-4or 5+) 12 Clerk Clerical 17. Fethar's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) William Windsor Bessie Windsor 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Department of Health e Important: If Item 27 is any injury or other tra gods. Daniel R. Benton/Son 205 Benjamin Ave., Salisbury, Md. 21801 20b. Place of Disposition (Nama of cametary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State Buriei 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) St. Johns U.M. Cemetery 3/25/98 Deal Island, Md. 21. Signature of Funeral Service Licansas 22. Name end Addrass of Fecility Hinman Funeral Home Part 1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Princess Anne, Md. 21853 Approximete interval Between Onset end Death **Physician** /Medical fmmediate Causa (Final diseasa or condition resulting in death) a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Causa (Disaase or Injury that Initiated events rasulting in death) Last and Dua to (or as a consequence of): physician Box 68760. Physician/Medical the Dua to (or as a consequence of) attending if for use as P.O. I Pert fl. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 ☐ Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE, Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy CORONARY ARTERY DISEASE completion of cause of death? pege 2 1 ☐ Yas 2 X No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: Be 25. Was casa refarred to medical 26. Place of Death (Check only ona) axaminar? 1X Yes 2 No Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 M DOA this After this 27. Mannar of Deeth 28a. Deta of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how Injury occurred 5 Pending invastigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Neturel 1 Yas 2 No 2 Accidant 8 Could not be detarmined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledga, daath occurred et the tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. 29a. Certifiar edical (Check only 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) July 03-22-98 D.M.E. D03599 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

State Registrar

MAR 2 4

31. Data filed (Month, Dey, Year)



which will be son your

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month ARTHUR Bennett William March 1998 8:19P 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number, 4c. County of Deeth The Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Davs 1 MM 2□ F -03-808 Yrs. Dec. 25, 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maky and 10e. Street and Number aylors Dorchester 10f. Zip Code 10g. Citizen of Whet Country? 21669 P.O.BOX 123 5 11. Marltei Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1945-1948 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Processing Line Helper Food 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) illiam Bennett HNNie DUNNOCK 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21669 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 123 Taylors ISland, Maryland Julia 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Lecation - City of Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/26/98 HURLOCK, Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faci 21. Signature of Funerel Service Licenses Henry Funeral Home 23e Party Enter the disease, or complications that caused the caused the mode of dying, such as cerdiec or respiretory errest, Approximate Approximate Approximate Intervel Between Onset end Death Immediate Cause /Final with Gram Rosilive cocci with shork. disease or condition resulting in death) Due to (or as a consequence of) Precumoua Due to (or as a consequence of): End stage revel disease chalyfu dependent 1997 Due to (or as a consequenca of): malnytrition Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?

Physician /Medicai Examine

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To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica

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Division of Vital Records, P.O.

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Physician/Medical

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Examiner

10a State

Directo

Funeral

à

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural; or itema 23a or 28a-f show any Injury or other traumatic event, the Master Examiner must be notified at

Bennett

Arthur Baltimore, Maryland 21215-0020

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

avenira of chronic derease Perypheral varcular direare

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Sulcide

4 Homicide

1 🗹 Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete end placa, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

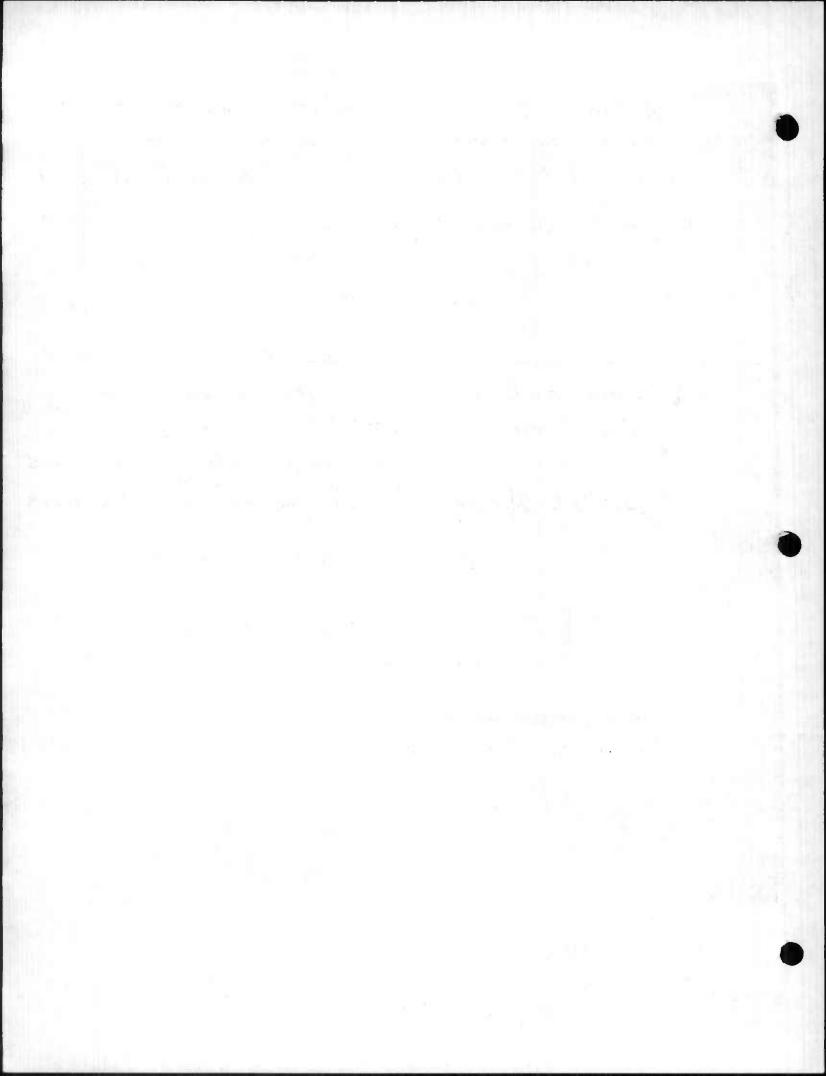
29b. Signature end title of cartifier

29c. License number 46020 29d. Date signed (Month, Day, Year) 3/20/98

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 506 Idlewild Ave. Easton, Maryland ALI

State Registrar

32 Registrar's Signature 31. Dete filed (Month, Day, Year) MAR 2 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death BLOWN 00 MANCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MAKYLAND INTON PLUCE HOSDITA 321030 If Undar 1 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 2√2F Months Days Hours 95 213 38 1572 Aug 17, 1902 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location IOd. Inside City Limits 1 Yes 2 ₩ o Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4511 Orleans Lane 20601 United States 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2☐No Yes, Giva 1 ☐ Yes 2 □ No Specify: Specify: White 30Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) School Teacher Public Education 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Robert Jump Smith Fannie A Barwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Bouta Number, City or Town, Stata, Zip Code) 4511 Orleans Lane, Waldorf, Maryland 20601 Jill Tribbet (NIECE) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 24, 0,998 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Removal from State Trinity Church Cemetery Waldorf, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of uneral Service Licensee Alexandria Ferry Road , Clinton, Md 20735 23a. Part. Enter the disease, or complication that caused the shock, or heart failure. List only one cause on each line. death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, Approximata Interval Between Onsat and Death Immediate Causa (Finai disaase or condition resulting in death) DITC CANDOVASCUCAN SIRSING Due to (or as a consequence of):

Physician /Medical Examiner

anding physician and use es the burial-transit

for u

signed I

page 2 s

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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edical Examiner

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Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

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permit. Peges 1 and 2 s Department of Heelth er Important: if Item 27 is any injury or other trau

Peges 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene.

Baltimore, Maryland 21215-0020

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Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Causa (Disease or Injury that initiated events rasulting in daath) Last

Part II. Other significant conditions co	ntributing to death but not res	sulting In the underlying c	eusa given in Part I.	23b. Did tobacco use con	ntribute to the cause of death? 3 Probably 4 Unknow			
				24a. Was an autopsy performed? 1 ☐ Yes 2 ₩No	24b. Were autopsy findings available prior to completion of ceusa of death? 1 Yas 2 No			
25. Was cesa refarred to medical examiner? 1 ☐ Yes 2 MNo	Hospital:	ER/Outpatient 3□ DC	Other	eath (Check only one)	(0-1)			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		8c. Injury at Work? 1 Yes 2 No		e 5 Rasidence 8 Other (Specify) 8d. Describe how Injury occurred			
3 ☐ Suicide 6 ☐ Could not be datermined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory	28f. Location (Street and Numb City or Town, Stata)	18f. Location (Street and Number or Rural Route Number, City or Town, Stata)				
29a. Certifiar (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of my kno iner: On tha besis of examina and mannar statad.	owiedga, daath occurred ation and/or Investigation,	at the tima, date and place In my opinion, daath occ	e, and due to the causa(s) and ma currad at tha time, date and place,	inner as stated. and due to the causa(s)			

State Registrar

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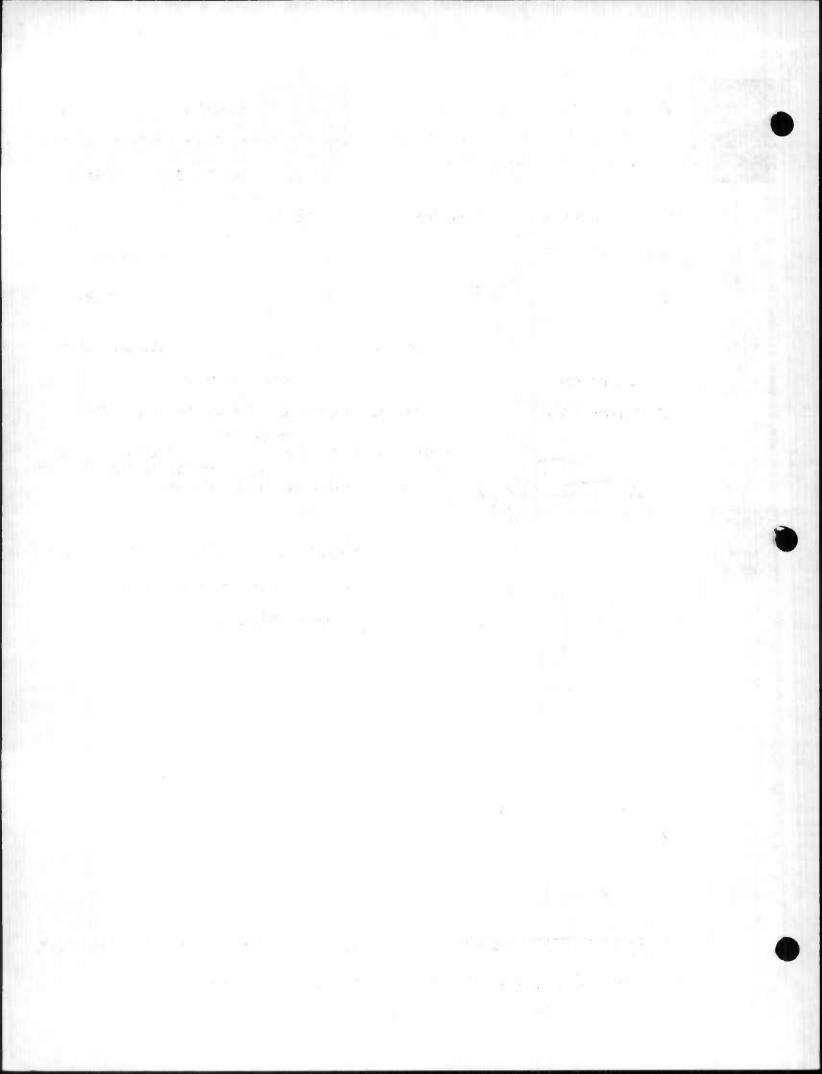
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addrass of person who completed cause of daath (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun

D-18545 MANCH 20, 1998



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1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		1. DECEDENT'S NAME (First, Middle, Last)			ERIIF	ICATE	UF	DEATH	1	REG. NO.		Т	3. TIME OF DEATH
		LAURA	AGNES	СО	OKE					March 22 1998 15:10			
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yr. 2277-14-4757 1 - M 2277F 101				IF UNDER 1	YEAR DAYS	IF UNDER 24	HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 19, 1	907	s. BIRTH Country	PLACE (State or Foreign MD)
pino	1	9e. FACILITY NAME (If not institution, give	YRS.	9h CITY	TOWN (OR LOCATION	TION OF DEATH 9c. COUNTY OF DEATH						
2, 3 should	<u>۳</u>	ALLEGANY CO. NUR		E		CUME			OF DE	nin		EGAN	
	5	RESIDENCE OF DECEDENT											
permit. Pages 1,	DIRECTOR		GANY			Y, TOWN OF							10d. INSIDE CITY LIMITS? 12 YES 2 NO
med	₹ SE	100. STREET AND NUMBER						I. ZIP CODE					NAT COUNTRY?
an. ransit	FUNERAL	119 Decatur Str						21502			US.	A	
1215-0020 or attending physician. r use as the burial-transit	BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	YES 2 WAR OR DATES.X	2 NO If yes, specify Cuban, Mexicen, Puarto Rican,				, Puarto Rican, atc.)	or No-		- American Indian, White, etc.		
r attend	ED	15. DECEDENT'S EDU (Specify only highest grade		16a. (DECEDENT'S	USUAL OC	CUPATIO	ON		16b. KIND OF BUS	SINESS/IND	USTRY	
2 E	COMPLET	Elementary/Secondary (0-12)	+)				ost of working						
YLAND Shite hospital be detached to at once.	MPI	6		Sal	es Pe	rso	n		Rose	nbau	m Dej	ot. Store	
the hose detach	00	17. FATHER'S NAME (First, Middle, Lest)		18. MOTHER'S NAME (Firs				the state of the s					
RYL May be	BE	WILLIAM HENRY							ANE HODEL				
MARYLAND retained by the hospit 5 should be detached	2	19e. INFORMANT'S NAME (Type/Print)	Manla a							Number, City or Town			
2 8		David A. Goad	Nephev						ue,	Cumberlan			
MOR age 6 m director,		20e. METHOD OF DISPOSITION 1 \(\) Burlet 2 \(\) Cremetion 3 \(\) Removet from State 4 \(\) Donation \(\) Other (Specify) \(\) Other (Specify) \(\) S. Peter \(\) Paul (21. SIGNATURE OF FUNERAL SETFICE LICENSEE								3-26-98 C	umbe:	rland	d, MD 21502
BALTIN as death. Pag the funeral dir wal.		21. SIGNAUSE OF TONEHAL SERVICE L	Complete Com			Me	rri	tt-Ada	of fac	Funeral H	ome,	P.A.	
BA nours after dead in by the fur or removal.		23. PART I. Enter the diseases, or	Mayor			40	4 D	ecatu	r S	treet, Cum	berl	and,	MD 21502
BOX 68760, arate be executed within nours hysician and completely filled in the sprior to burlal, cremation, or restruction to the returnation event, the media		immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a. DUE TO	OR AS A CONS			ب	PI	SE	35			Onset and Death
P.O. Bath certificate tending physical Hygiene party or other	ERTIFIC	CAUSE (Disesse or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d											
Signed by Health and Investment of the signed by Health and Was any Ir	EDICAL	PART II. Other significant condition CON 6 7 7 0 PINGERS	TX	P1 11/2 P				Part i. 24a. WAS AN PERFOR	RFORMED? AW		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 70		
AL RE law requires been of the 23 short	2	DID TOBACCO USE	CONTRIBUT	E TO CA	USE O	F DEAT	TH '	YES 🔲	NC) A			
TA The steep age of the steep o	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	☐ ER/Outpatient	3 DOA	OTHER 4 Nurs	:	LACE OF DEA		8 Other (Specify)			
OF V PHYSICIA this certif with the	PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF (Month, D		28b. TIR	JURY	WC	JURY AT ORK?		28d. DESCRIBE HOW I	NJURY OC	CURED	
ON O DING PHYS After this death with		2 Accident Investigation	28a PLACE O	E IN HIRV A.	home form	M foots		YES 2 🗌 I	NO	001 100171011 (01			
ISI TTEN TOR: after	田田	3 Suicide 6 Could not be 4 Homictde datermined						atreet, factory, office 281. LOCATION (Street and Nu. City or Yown, Stete)				mber or Rural Route Number,	
로 그 이 트	F	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS								to the cause(s) end man			end menner es stated,
FUN WITH	Ö	296. SIGNATURE AND TITLE OF CERTIFY	Я				_	29c. LICENS	SE NUM	BER	29d, DAT	E SIGNED	(Month, Day, Year)
TO THE HOSPIT TO THE FUNERA DE filed within 7	BE (1 N 6	any					0		868			23, 1998
7-0=	2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAU	SE OF DEATH (17	TEM 27) (Type	e, Print)		. 7	, .			04	1110
Char		Dr. R. Barrera	500 Memo	rial Av	renue	Cuml	oer.	land,	MD	21502			
1000		MAR 23 1998	32, REGISTRA	AR'S SIGNATURE									
					***************************************			-					DHMH 16 Bey 1/9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) ornish 0817 1998 march 15 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give straet and number) WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. jast birthday) 1□ M 20%F Days Hours Min 216-14-9745 Yrs. MD Usual Residence of Decedent 10d. Inside City Limits 10a. Stata 10c. City. Town or Location Wicomico MARdela MD 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21837 9463 Thol 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Giva Yeer or Datas: 14. Raca - American Indian. 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Navar Marriad 2 □ Married 1 Yes 2 No Specify: Blac 318 Widowed 4 □ Divorced 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa, DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) abover omes 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) Wilmore MAddok WATERS Ger Hude 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21837 S:ster UD Nichols 9463 AThol RD MArdela)ora 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Data 20c. Location - City or Town, State Wes ey Lemon. 22. Name and Address of Facility Atthony E. WA Hampde 1 Burial 2 Cremation 3 Removal from State 3-21-98 4 ☐ Donation 5 ☐ Other (Specify) Vincess Anno MD ohn Comotify 21. Signature of Funare Sarvice Licenses . WARD 30639 Hampden Are MD 21853 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Immediate Cause (Final disease or condition resulting in death) 1 low Dua to (or as a consequence of) Dua to (or as a consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? TOYOS 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? benend Pt 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 € No

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Itsm 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Itsm 27 Is marked other than "natural", or its

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

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or Attend after dead Director:

To the Hospital within 24 hours a To the Funeral D

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Diseasa or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Chack only ona) Other: 4₽ Nursing Home 5 ☐ Rasidence 6 ☐ Othar (Specify)

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 27. Manner of Death 5 Pending Investigation 1- Natural

6 Could not be

2 Accident

3 Suicide

4 Homleide

1 Inpatiant 2 ER/Outpetient 3 DOA 28a. Data of Injury (Month, Day Year)

28h Time of

28c. Injury at Work? 1 🗌 Yas 2 No 28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

UW

Hospital:

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29b. Signatura and titla of certifian

29c. Licensa number

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 2 0 1998

04 31. Date filed (Month, Day, Year)

Brue 32. Registrar's Signature

State Registrar

pleasald I specific. Un WELL OF A CANA . A milyald secolar - And - but -Here agreement of the white double ox The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death hapman 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 10:45pm 1998 March /Medical Francis Warren Chapman 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lions Manor Nursing Home Allegany

9. Birthplace (State or Foreign Country) Cumber land If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Data of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days Yrs Director 220-10-0400 Usual Residence of Deceden Jan 5, 1921 the Marylend 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 28a-f show 7 is marked other than "natural, or itams 23a or 28a-f sh traumatic event, the Medical Experimen must be not fed Director 1 ☐ Yes 2 ☐ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with Funeral 14718 Brant Road SW 21502

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced WWII 16b. Kind of Business/industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Manager Curing Dept. Tire Co 12 Tire Company 17. Fathar's Name (First, Middla, Last) Be if Itam 27 is marked o John A. Chapman Catherine E. (Trapp)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place)

20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata other altimore, Donna Kennedy-daughter 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 Department Important: If any Injury or Rocky Gap Veterans Cem 03/23 | Flintstone MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumber land MD 21502 the mode of dying, such as cardiac or respiratory errest. 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physiclan /Medical Immediate Cause (Final disaasa or condition resulting In death) **Examiner** Examiner The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Last Due to (or a a consequence of) P.O. Box 68760, been signed by the ettending physician should be detached for use as the buria Physician/Medical Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 1 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of causa of death? certificate has 1 ☐ Yas 2 0 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 26. Piece of Death (Check only one) Other: Certification: To 297 No 1 Inpatient 2 ER/Outpatient 3□ DOA 400 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury ours efter deeth.

Meral Director: Af 1 Yes 2 1 No 2 Accident 6 Could not ba 3 Sulcide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide within 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

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21502

NDD., Lions Manor Nursing Home, Seton Drive Ext., Cumberland MD

State Registrar 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

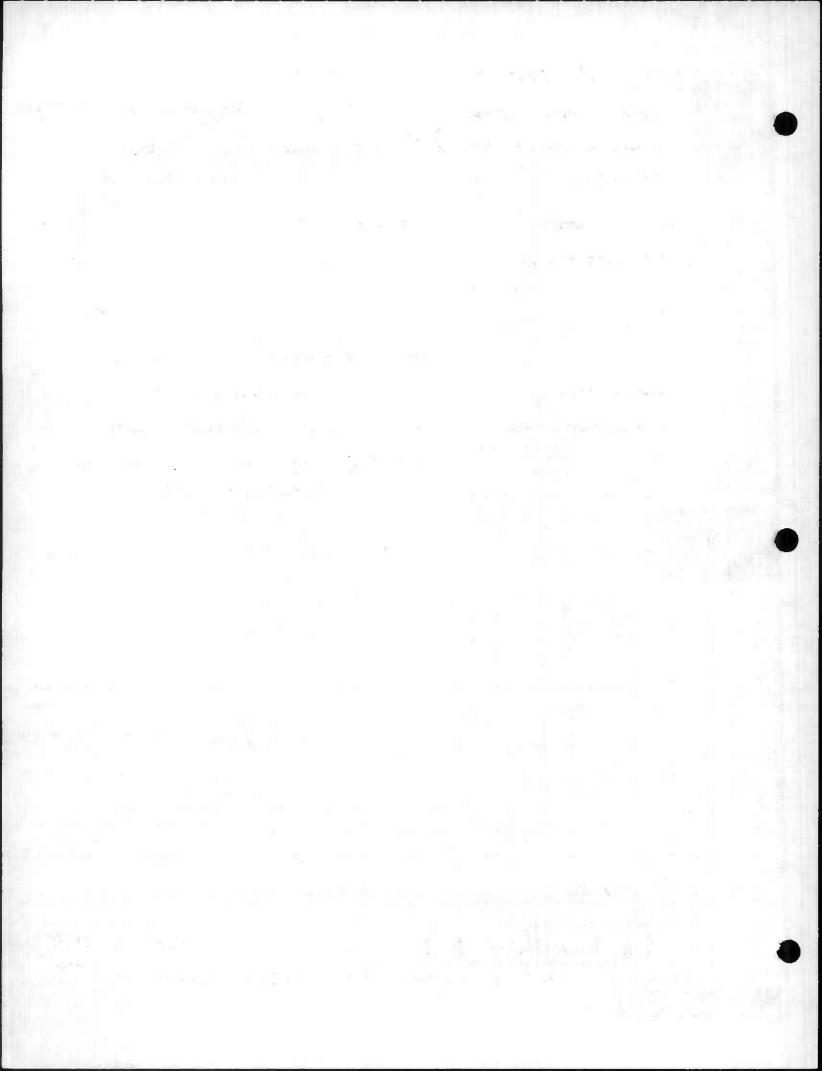
32. Registrar's Signature

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31. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

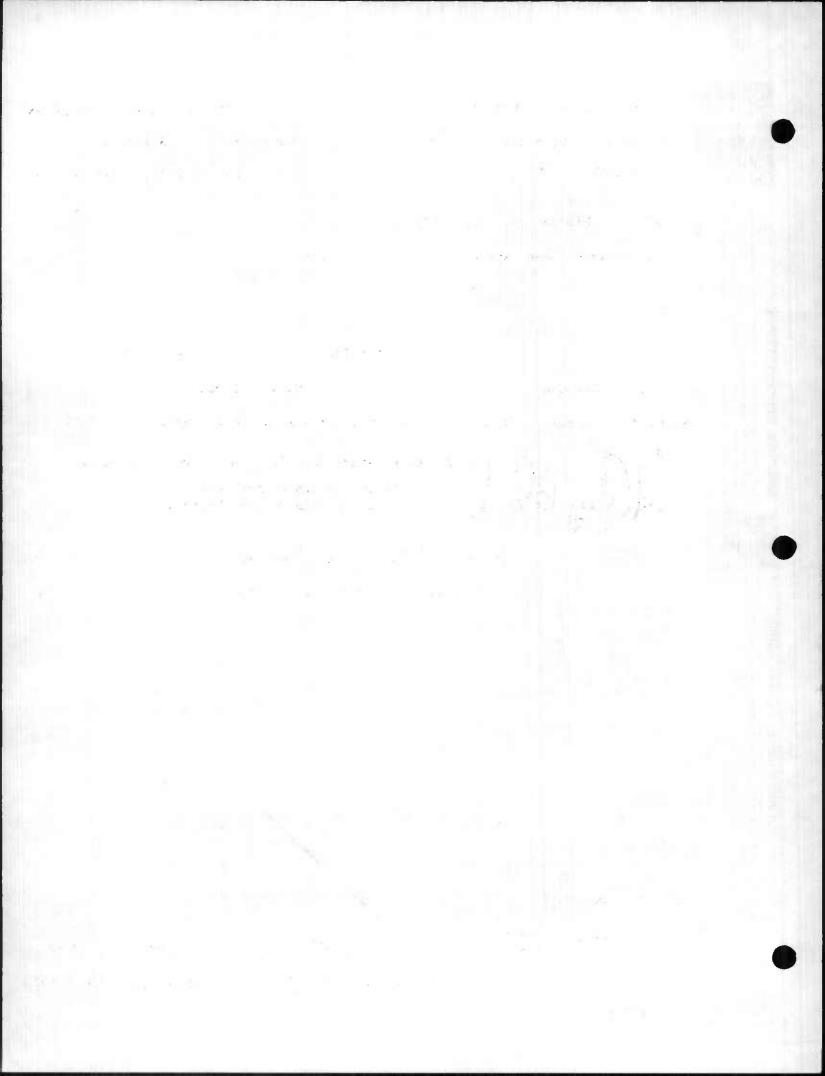
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev **Physician** Chapman Joseph Holmes MARCH 15 1998 05:50 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Sacred Heart Hospital Cumberland Allegany If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Yeer 9. Birthpleca (Stete or Foraign Country) West Virginia 7. Age (In yrs. lest birthday) **Funeral** 100 M 2□ F Months Days 232-26-2672 Yrs. Feb 8, 1921 Director Usuel Residence of Decadent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours effer death with the Manyian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic event, the Medical Examples Traumatic events and the Medical Examples Traumatic 1 XYes 2 No Director Mineral Keyser 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Apt 602 500 Carskadon Lane 26726 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Coilege (1-4or 5+) Electrician Railroad 18 Mother's Neme (First Middle Meiden Sumema) 17. Father's Name (First, Middle, Last) Wilbur Chapman Cora Koontz 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Retationship (Type, Print) 500 Carskadon Lane Apt 602 Keyser, WV Hazel May Chapman Wife 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Crametion 3 ☐ Removal from Stata Philos Cemetery Mar 16, 1998 5 Other (Specify) Westernport, MD Service Licen 22. Name and Address of Facility Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete Interval Between Onset and Deeth 23a, Part1 **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting tn deeth) Respirator Johns Examiner Examiner Recurrent 2 yrs The law requires that the death certificate be executed physician end the buriel-trensit Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 80 esn 23b. Did tobacco use contribute to the cause of death? ed by the detached Part fl. Other stanificant conditions contributing to death but not resulting In the underlying cause given in Pert I. signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy findings available prior to completion of cause of deeth? been si 24a. Was en eutopsy performed? Completed certificate has b lirector, page 2 s 1 ☐ Yes No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ¶ Inpatiant 2 ER/Outpatient 3 DOA Sinis funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation offer death Director: A d in by the f 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aft To the Funeral Discompletely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner steted. 29a. Certifier edical (Check only one) the 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MARCH , 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Cumberland nus 909-B Seton Drive M.D 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) MAR 2 0 1998 a successful

DHMH 16 Rev 6/95

Registrar



Director

Funeral

by

, Funeral Director

death with the Maryland r than "natural", or frems 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours efter Hygiene.

Baltimore, Maryland 21215-0020 Completed of Health and Mental Hygie Hear 27 is marked other to other traumetic event, in Be Pages 1 end 2 should be nent of Health and Mental 2 nt of Health at: If item 27 is Department of Important: If any injury or **Physician** /Medical Examiner Examiner The law requires that the death certificate be executed bunial-trans P.O. Box 68760, the attending physician hed for use as the buria Physician/Medicai á Division of Vital Records, þ Completed certificate Attending Physician: Be 10 this Certification: After death. within 24 hours after deat To the Funeral Director: 6 Medicai 3

EGLE NURSING HOME CUMBERLAND ALLEGANY Hours Min. 8. Date of Birth (Month, Day, Year)
DEC . 28, 1905 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 1 ☐ M 2 🖾 F Yrs. 92 MARYLAND Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location MD ALLEGANY LONACONING 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 57 JACKSON STREET 21539 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE 3 Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) WAITRESS RESTAURANT 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Surname) HARIETT ETTA MIDDLETON JOHN HENRY HARTUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) CHARLES W. HEVEL/SON 18633 WHITE OAK DR., S.W.-RAWLINGS, MD 21557 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from State SUNSET MEMORIAL PARK 3/13/98 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD 21. Signature of Funeral Sarvice License 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each lina. 23e. Pert1. Enter the . seese, o com shock, or heart f ilure. List only Immediate Cause (Finel disease or condition rasulting in death) Cerebral Vascular Accident Due to (or es a consequenca of): Advanced General Arteriosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Lest Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death?

Chronic Obstructive Pulmonary Disease Profound Depression

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

10d. Inside City Limits

21502

Approximate Interval Between Onset and Death

24 hours

10 years

1 ☐ Yes 2 ☐ No

1 Ves 2 □ No

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending Investigation 1 Natural

Other: 410 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

21539

26. Place of Death (Check only one)

1 ☐ Yes 2 No

6 Could not be determined 28e. Piace of injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the bests of examination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier I Loniles

29c. License number D07004

29d. Deta signed (Month, Day, Year) March 11,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L.R. MILES, M.D.

2 Accident

3 Suicide

29a. Certifier

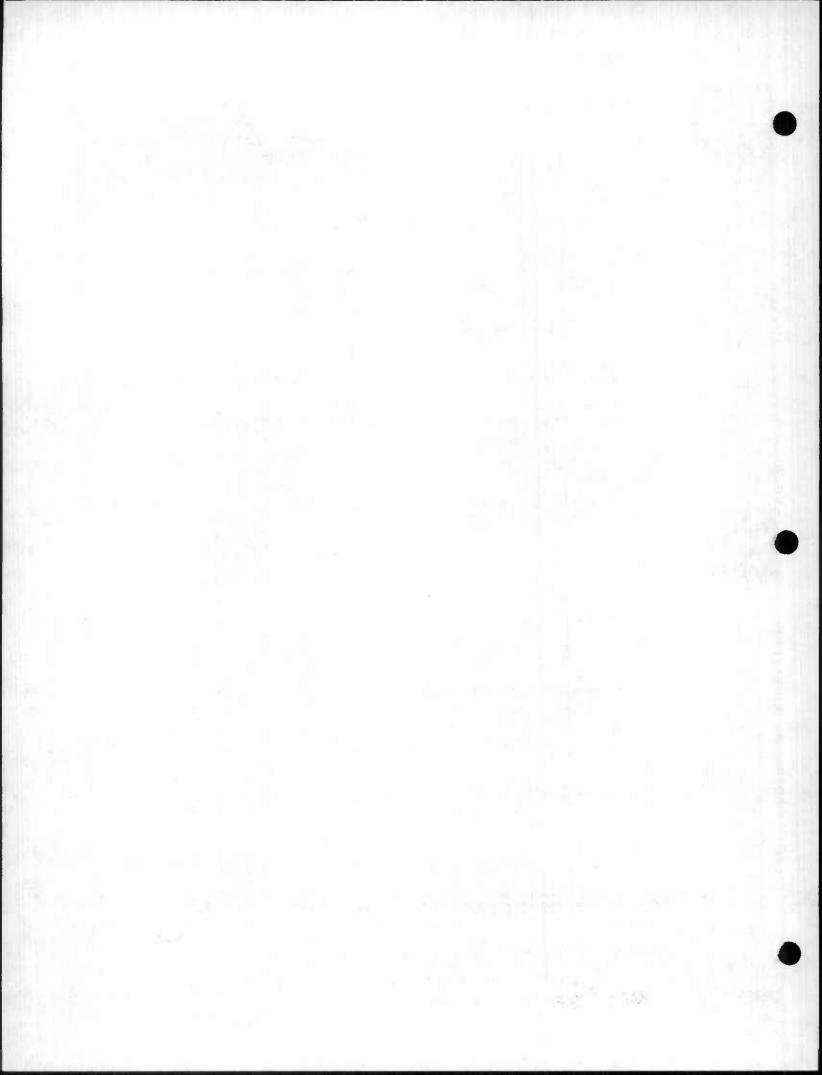
4 Homicide

(Check only

10 ST. PETER'S PLACE, LONACONING, MD 1 A2 Registrare Signature

State Registrar

nes



Amended #8, Per Rondiele Broods, 3/17/98, Allegan, 0

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q R 101.05

maging cov.	Certificate of	Death	Reg. No.		
Physician * /Medical	1. Decedent's Name (First, Middle, Last) Robert T. Cuthbertson	2. Date of Do Month	Day Yeer 3. Time of Death		
Examiner Funeral Director	4a Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 5. Social Security Number 6. Sex 1 M M 2 F 7. Age (In yrs. last birthdey) Months Days 216-05-2952 Usuel Residence of Decedent		WICOMICO 9. Birthplace (State or Foreign Country) 7, 1914 MD		
show	10a. State 10b. County 10c. City, Town or Location	1 1 1 7 1	10d. Inaide City Limits 1 ☒ Yes 2 ☐ No		
vith the Mer or 28e-f si be next to	DE Sussex Colonial East, Re				
th with the Meryland 23a or 28a-1 show ant be northed at all Director	10e. Street and Number 10f. Zip Code 22 Powder Horn Lane 19971		10g. Citizen of What Country? USA		
5-0020 72 hours after death v neturel; or items 23a and Exercises want efted by Funeral	11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1★ Never Married 3 □ Widowed 4 □ Divorcad 12. Wes Decedent Ever in U.S. Armed Forces? 1★ Yes 2 □ No Army If Yes, Give Year or Dates: ₩W II 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify Yes or Niben, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
T 4 1 3 3	Elementary/Secondery (0-12) College (1-4or 5+)	upetion e during most of working red)	16b. Kind of Business/Industry		
Maryland 212 d 2 should be filed within th and Mental Hygiena. The marked other then treumatic event, the u To Be Comp	10 0 Factory worke 17. Father's Neme (First, Middle, Last) David T. Cuthbertson	18. Mother's Name (First, Middle Nellie Todd	Auto dle, Malden Sumame)		
P.O. Box 68760, set the death certificate be executed to the estanding physician and estached for use as the buriel-transit are the buriel-transit. Physician/Medical Examiner	23a. Part VEnter the disease, or complications that cause of the deeth. Do not enter the mode of so shock, or heer failure. List only one cause on each whe. Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate	march 10 netery 1998 ress of Facility McKenzie Funeral n Street Jonaco Wing, Such as cardiac of respiratory 2-28-98 C C A B L Suryan given in Pert I. 23b. Dic	Moscow Mills, MD Home P.A. Painest, MD 21539 Approximate Interval Between Onset end Death / 0 - 4		
al Records, P. The law requires that the has been signed by page 2 should be detail. Completed by Ph		24a. Wa	s an autopsy formed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No		

Robert Cuthbertson

Division of Vital Reco

To the Hospital or Attending Physician: The law requivilin 24 hours after death,

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should

Medical 4+1 nus

Registrar

Be

Certification: To

29b. Signeture end title of certifles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 DInpatient

28a. Date of Injury (Month, Day Year)

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No

5 Pending

Investigation 6 Could not be determined

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 - Homicide

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D11648

28c. Injury et Work?

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

3-13-91

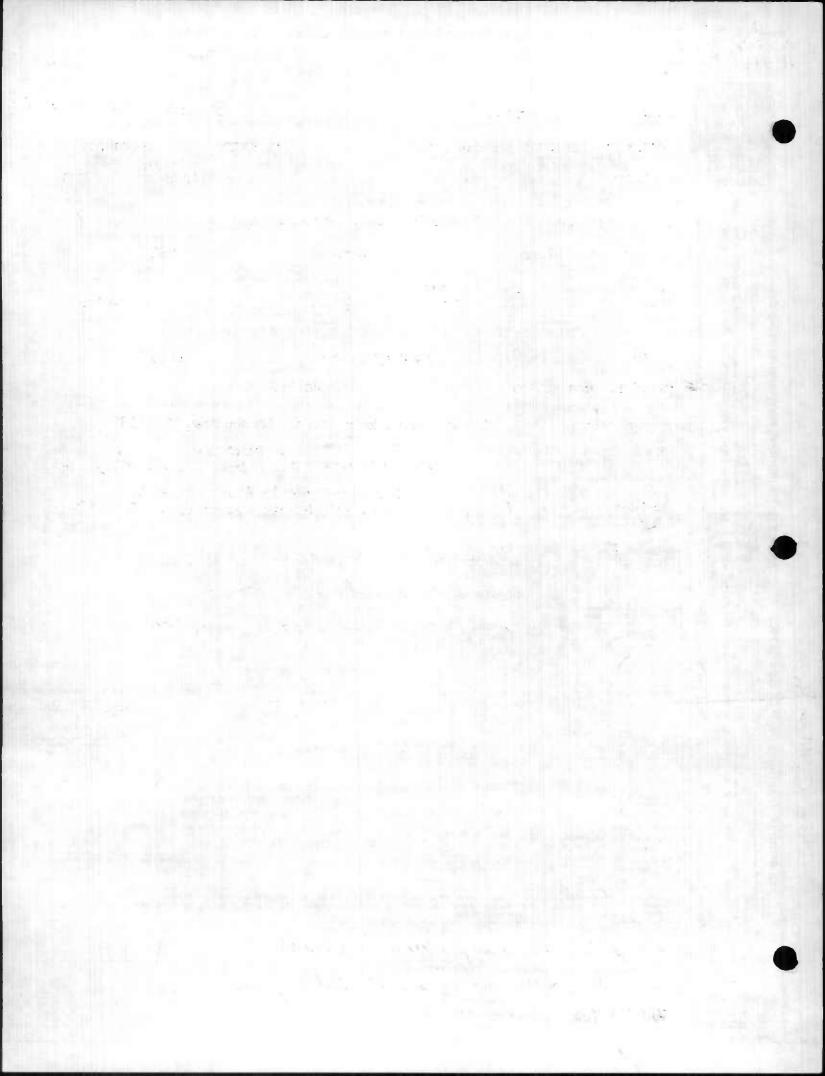
28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Piece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

Bluffi Rd. lodd 22. Registrar's Signature 31. Dete filed (Month, Day, Year) MAR 1



CORNEL DYE	IUS		State of Marylar		partment of Fertificate of			iene 98	10426	
Dhy:	sician edical	Decedent's Name (First, Middle, La CORNELIUS	ALVIN		2. Date of Dee Month MARCH		Year 3. Time of Death 4 • 55P. M.			
13	niner	4a Facility Name (If not institution, gir	ve street and number)			4b. City, Town, o	r Location ot Deeth	4c. County	of Death	
***		CUMBERLAND MEMOR		for a filt at sto	if Under 1 Year	CUMBERI If Under 24 Hr		ALLE		
Fune Direct			Sex 7. Age (In yrs.	Yrs.	Months Deys	Hours Mir		, Year)	Birthplace (State or Foreign Country) MD	
and tand		10a. Stete 10b. County	10c. Ci	ty, Town or	Location				10d. Inside City Limits	
Manyian H show	to	MARYLAND ALLEGA	NY CU	JMBERL	AND				1 Yes 2 □ No	
h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Country?	
ih wit	al D	512 FECTIG AVE	NUE		21502			USA		
and 21215-0020 be filed within 72 hours efter death with the Manyland hal Hyglene. of other than "naturel", or items 23s or 23s-1 show event.	y Funeral	11. Marital Stetus 1 □ Never Married 2 → Married	12. Wes Decedent Ever in U Armed Forces? 1 √2 Yes 2 □ No If Yes, Give	J,S. 13	Was Decedent of Hif Yes, specify Cub	dispanto Origin? (en, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		e - American Indien, ck, White, etc.	
5-0020 72 hours of neture!; or	d by	3 Widowed 4 Divorced	Yeer or Detes: WWI]	1	a de alla Marral Ossari			10h Kind of Bu		
within 72 one.	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)		(Giv	edent's Usuel Occup re kind of work done DO NOT use retire ger of Bo	during most of w d)	orking	Seven-		
filled will the three th	ပိ	17. Father's Name (First, Middle, Last	1	Hana	ger or bo		eme (First, Middle, I			
Maryland 2 d 2 should be filed th end Mental Hygi 7 is marked other traumatic event.	To Be	WILLIAM EDWA				RUTH S		narous our ann	9,	
nd 2 should lith end Mer 27 is marker traumatic		19a. Informant's Name/Relationshtp	(Type, Print)	19b. Me	iling Address (Street	and Number or I	Rural Route Number	r, City or Town,	State, Zip Code)	
P TO N L		RUTH DYE	WIFE		FECTIG AV	E., CUME				
0 00 - 5		20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20c. Location - City o								
Saltim permit. Pag Depertment Important: I	once.	21. Signeture of Funeral Service Lica			22. Name and Addre	ess of Facility				
Physicia //Medic Examin	an al er	23a Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Multiple	th. Do not e	rritt-Ada 4 Decatur nter the mode of dyi equence of):				21502 Approximate Interval Between Onset and Deeth	
D, axecuted an and rial-trensit	ш	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equence of):					
daath certificete be aw e attending physician ad for use as the burial	Physiclan/Medical	Ceuse (Disease or Injury that initiated events resulting in death) Last	C. Due to (or as a cons	equence ot):					
BOX ath cert	lan		U .							
D hat the deby the detached	by Physic	Atherosclerotic Conditions		sulting in the	g in the underlying cause given in Part I. 23b. Dld tobacco uss 1 Yes 2 N				ntribute to the causs of death?	
corc inper v been s	leted						24a. Was a perfor	an autopsy med?	24b. Were autopsy findings eveilable prior to completion of cause of death?	
The law	mo						199	es 2 No	1 ☑Yes 2□ No	
Vital I	e C	25. Was case referred to medicat				28. Place of D	eath (Check only or	ne)		
	To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2 C	XER/Outpati	ient 3 DOA Ot	her: 4 Nursing	Home 5 Resid	ence 6 Oth	er (Specify)	
After fune	Certification:	27. Menner of Death 1 Naturat 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ry at rk?] Yes 2 ☑ No	28d. Describe h		ciclout	
DIVISION Attended after death Director:	Ca	3 Suicide 6 Could not	10		street, factory, office		,		per or Rural Route Number,	

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 21,1998

111 Penn Street, Baltimore, Maryland 21201

12+1 pas

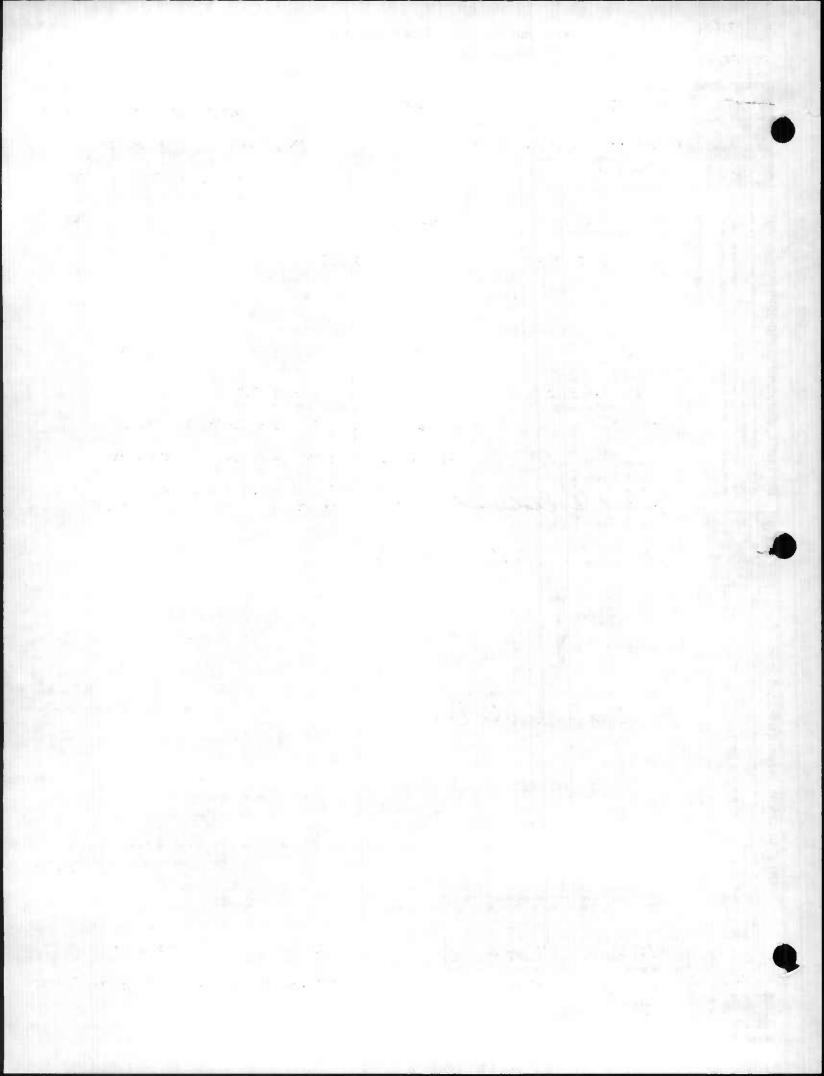
Registrar

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chufe W. 11 32. Registrar's Signature

29b. Signature and title of certifier

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Alma J. Dver March 20, 1998 1:30 am 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Memorial Hospital & Medical Center Cumberland **Allegany** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day Year) 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Sex 1□ M 2□ F Deys 214-34-1336 78 Vrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1X Yes 2 No 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? 235 Paca Street Apt 901 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker own hame 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Elmer L. Weimer Johanna Hyde 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Johanna Brown-daughter 22711 Oldtown Road SE; Oldtown, MD 21555 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Plece of Disposition (Neme of cametery, cremetory or other piece)
Hillcrest Memorial Park 20c. Location - City or Town, State 03/23 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Scarpelli Funeral Home, P.A. Cumberland, MD 21502 ames 23a. Perty Enter the disease, or complications the shock, or heert feilure. List only one ceus death. Do not enter the mode of dving, such as cerdiac or respiratory errest. Approximete interval Between Onset end Death a Bilateral Pneumonia 2 days Due to (or es e consequence of): Due to (or es a consequence of): Due to (or es e consequence of): 23b. Did tobacco uea contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

The law requires that the death certificete be executed

P.O. Box 68760.

Records,

Physician

/Medical

Examiner

10e State

MD

Funeral

Director

ral', or items 23s or 28s-f show Examiner rount be notified at

"natural", or

lith end Mental Hygiene. 27 is marked other than "r r traumatic event, the Mad

. Peges 1 end 2 should be fill ment of Health end Mental Hant: If Item 27 is marked oth jury or other traumatic even

Director

Funeral

Completed by

Be

the Maryland

with

death

filed within 72 hours after

21215-0020

Baltimore, Maryland

Division of Vital 214-34-1336

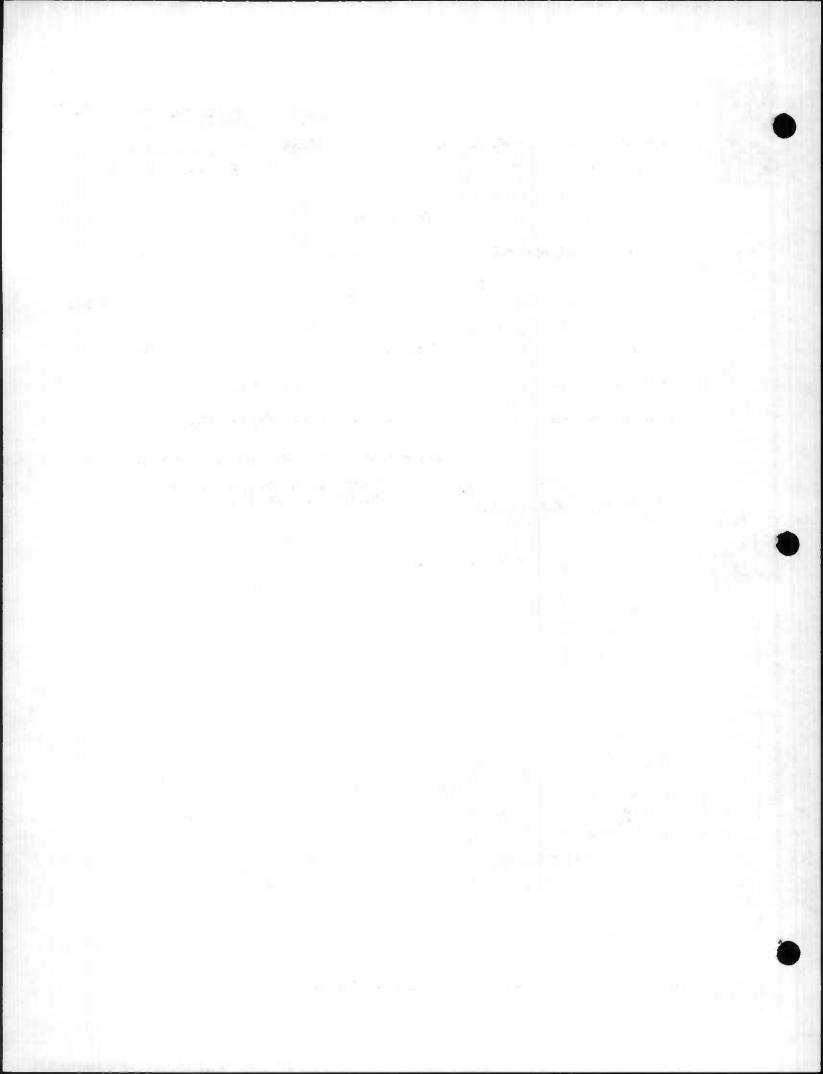
Hospital or Attending Physician:

the the

0

yours Registrar

Immediate Cause (Final disease or condition resulting in death) Examiner pue Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical the been signed by the etter should be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. by Completed page 2 s After this certificate filled in by the funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 250 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral D Medical 29a. Certifier 1 🗷 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of o 29c. License number 29d. Dete signed (Month, Dey, Yeer) 033280 March 20, 1992 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta, M.D., Memorial Medical Building, Cumberland, MD 21502 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature State Abi Devitor B MAR 2 3 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

STEPHANIE

DALEY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

J.

7. Age (In yrs. last birthday)

24

Reg. No.

Physician /Medical Examiner

STEPHANTE

DALEY

2. Date of Death Month MARCH

3. Time of Death 1998 12:49P.M.

4a Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER 4b. City, Town, or Location of Death SALISBURY

21, 4c. County of Death

WICOMICO

Funeral

1 M 2 M F 224-21-3949 Usual Residence of Deceden

Accomac

10b. Counts

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Months Days Hours

Birthplace (Stete or Foreign Country)

Director

7 is marked other than "natural", or Itams 23a or 28a-f shov traumatic avent, the Medical Examinat must be notified at

Pages 1 end 2 should be filed within 72 hours after death with neart of Health and Mertal Hygiena.
Artif filem 27 is marked other than "natural", or items 23a or introduced other than the process of the present of th

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

To

Certification:

edicai

the Maryland

10e State Virginia 10c, City, Town or Location

Yrs.

Sept. 9,1973

Maryland

10f Zip Code

Tangier

10d. Inside City Limits WYes 2 No

10e. Street and Number

5. Social Security Number

4417 Williams-Wheatley Road

23440

10g, Citizen of What Country?

11. Marital Status

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 Decedent's Name (First Middle Last)

12. Was Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

USA

Elementery/Secondary (0-12) 12

Clerk

Grocery

17 Father's Name (First, Middle, Last)

Mark Crockett

18. Mother's Name (First, Middle, Maiden Sumeme) Trudy Autry

19a. Informant's Name/Relationship (Type, Print) Terry J. Daley, Jr. (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tangier, 4417 Williams-Wheatley Rd.-PO Box 293-

23440

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) Thomas Cemetery

20c. Location - City or Town, State 3/26/98 Tangier, VA

21. Signature of Funeral Service License

Robert H. Bradshaw

22 Name and Address of Facility Bradshaw & Sons Funeral Home

306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate interval Between Onset and Death

Physician /Medical Examiner

sician and burial-transit

physician the burial

signed by the a

certificate has b lirector, page 2 s

sins funeral

After

death.

hours after deal

To the I within 2. To the I complete

 24 hours after
 Funeral Dire
 Netely filled in b Hospitai

98 use

the death certificate be axecuted

The lew requires thet

or Attending Physician:

Department of Important: If any Injury or

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

immediate Cause (Final disease or condition resulting in death)

a Intra-Abdominal Hemorrhoge

Ruptured Spknic Artery
Due to (of as a consequence of):

Due to (or as a consequence of)

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of deeth?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 Nes 2 No

25. Was cese referred to medical examiner? 1⊠ Yes 2□ No 27. Menner of Death

5 Pending investigation

6 Could not be determined

Hospital:

2 ER/Outpatient 3 DOA npatient 28a. Date of Injury (Month, Dey Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Piece of Death (Check only one)

29a. Certifier (Check only one)

1 Neture

2 Accident

4 Homicide

3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner es stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifier

29c. License number

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

O.C.M.E.

Chutems VennisJ

32. Registrar's Signature

Jahr Davidson Randall 31. Date filed (Month, Day, Year) MAR 25 1998

P.O. Box 68760, Division of Vital Records,

> Registrar DHMH 16 Rev 6/95

State

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

MARCH 22,1998

David or other state

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day Yaa **Physician** Charles Allen Edmiston, Sr. MARCH 18 1998 14:05 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Undar 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 220-40-1484 55 Director 16-Aug-42 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene.
Int. If Item 27 Is marked other than "netural", or items 23s or 23s-f show unt. If Item 27 is marked other than "netural", or other traumatic event, the Medical Experiment and be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yas 2 No Directo Maryland Allegany Cumberland 10e. Street and Number 12616 Bowling Street 10f. Zip Code 10g, Citizan of What Country? 21502-U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces?

12 Yas 2 □ No If Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes X No Specify: Specify White þ 3 ☐ Widowed 4 ☐ Divorced 1965 Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver and Inspector School Bus Company 12 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Sumema) Be John Shaffer **Dorothy Elizabeth George** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Janet Edmiston 12616 Bowling Street Cumberland Maryland 21502-20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of important: If any injury or Rocky Gap Veteran's Cemetery 20-Mar-98 Flintstone, Maryland 21. Signetura of Funeral Servica Liou 22 Name and Addrass of Facility 29 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23. Pm1. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final VENTRICULAR FIBRILLATION FULL HOURS diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner ACUTE MYOCARDIAL FOUR MOVES INFARCTION physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequenca of): 98 esn signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CENEBRAL ANOXIA þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed RESPIRATORY ARREST page 2 s 1 Yes 200 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 □ ER/Outpatient 3 □ DOA this funeral 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of After 1 Naturel 2 Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Invastigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, atreet, factory, office building, etc. (Specity) 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide 124 hours a Hospital Time Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as attend.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune complately fi (Check only one) 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 033417 MARCH /9, 1998 5 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Thus LAVALE, MARYLAND MMES R. MOEN 1068 NATIONAL HIGHWAY MO 21502 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State discher l'english

DHMH 16 Rev 6/95

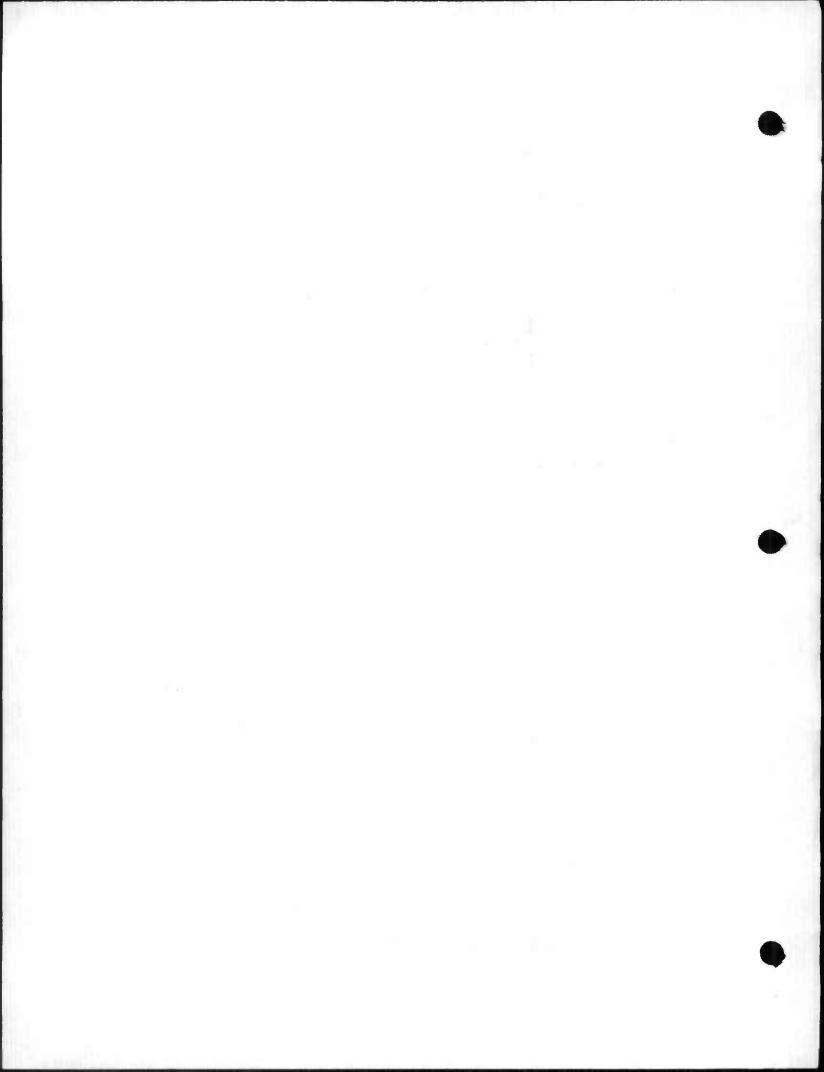
Registrar

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	COLTA

		1 - FOR STATE REGISTRAR	STATE OF MA			OF HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, La.	st)				2. DATE OF DEATH		3. TIME OF DEATH		
		Zaffino Anti	ony Else				March 14	1998	12;20 AM		
p		219-60-0254	1 ★ M 2 □ F	AGE (In yrs. last birth	RS. MONTHS C	DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 10	1954°	Maryland Maryland		
2, 3 should	стов	90. FACILITY NAME (If not institution, ghaterview Heatersteen)		Center		own or location of d isbury	EATH	Wicor			
Pages 1.	REC	10a. STATE 10b. COU	NTY	10c	CITY, TOWN OR	LOCATION			10d. INSIDE CITY		
permit. Pa	AL DIF	Maryland W:	icomico		Salish	ury 101, ZIP CODE		10a CITIZEN	LIMITS? 1 ☐ YES 2 NO OF WHAT COUNTRY?		
Sit	ER/	413 Booth St	reet			21801		U.S			
or attending physician. r use as the burial-transit	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 NO	If y	S DECENDENT OF HISPA es, specify Cuben, Mexico YES 2 NO Specif	an, Puerto Rican, atc.)		RACE — American Indian, Black, White, etc. Specify:		
r attendir use as th	8	15. DECEDENT'S E (Specify only highest gri	DUCATION ade completed)	16e. DECEDE	NT'S USUAL OCCI	UPATION ing most of working	16b. KIND OF BU	SINESS/INDUSTF	Black		
e pital	COMPLETER	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)	Ille. Do M	or use retired.)	ing most or working	None				
the hose detach	Ö	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maiden				
tained by should be stiffled at	BE	William Else	Y	10h MAI	INC ADDRESS (S	Annabe	elle Conw	-			
2 2 2	욘	Annabelle Gale	e (Mother)	423	Robin	son St.S	alisbury,	Md.21	801		
must must		20e, METHOD OF DISPOSITION 1	emoval from State	cometery, cremetory Head		100	3/2D Qua	cation — city of			
bath.		21. SIGNATURE OF FUNERAL SERVICE *** **Hadyo** B:		+	St	ME AND ADDRESS OF FA	neral Hom	ie			
		23. PART I. Enter the diseases, of			82	1 West Ro	d.Salisbu	ry,Md.			
y filled in by the tion, or remova		shock, or heart failur IMMEDIATE CAUSE (Final	e. List only one cause	on esch iine.			in an esterac or respi	ratory arrest,	Approximate interval Between Onset and Death		
completely file ial, cremation,		disease or condition resulting in death)	SDUE TO (OF	AS A CONSEQUENC	PALLET				74 weeks		
	N	Sequentially list conditions,	b	End	smage +	2105 - Dene	nh4		> 6 man (kis		
tracian pe	CATION	If sny, leading to immediate cause. Enter UNDERLYING	OUE TO (OF	AS A CONSEQUENCE					>6 man lks		
1 1 de 1	RTIFIC	CAUSE (Disesse or injury that initiated events resulting in death) LAST									
	CE		d								
at the dear and Menta and Menta it injury.	CAL	PART II. Other significant conditi	ons contributing to de	ath but not result	ing in the unde	riying cause given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
PHYSICIAN; The law requires that it this certificate has been signed by with the State Dept. of Health and rided, or Item 23 shows any in	MEDIC						1 _ YES 2	XNO	OF DEATH?		
law required as been of 23 she		DID TOBACCO USE CON	TRIBUTE TO CAUS	SE OF DEATH	YES NO	UNCERTAIL	NX		1 123 2 10		
V: The cate has State D	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:						
SICIAN certifi h the S	높	27. MANNER OF DEATH	1 Inpetient 2 EF	JURY 28b.	TIME OF 28	g Home 5 🗆 Reeldence	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURE	0		
	ВУ Р	1 Netural 5 Pending 2 Accident Investigatio		Year) IJURY — At home, fa	M M	WORK?					
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 6 Could not b 4 Homicide datermined	building, etc.	(Specify)	in, sireet, tactory	, ovince	28f. LOCATION (Street e City or Town, Stelle)	and Number or Ru	ral Route Number,		
Z ZZ =	COMPLET		YSICIAN: To the best of my NER: On the bests of exam						se(e) end menner ee stated.		
TO THE HOSPI TO THE FUNER be filed within	O BE	296. SIGNATURE AND TITLE OF CERTIF	7.17			29c. LICENSE NUI		29d. DATE SIGN	NED (Month, Day, Year)		
	Ţ	30. NAME AND ADDRESS OF PERSON?	WHO COMPLETED CAUSE (OF OEATH (ITEM 27) (Type, Print)	V NH			016-1		
5		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE		V NH SE	4/15 bar R-/	md ?	(1801		
		MAR 181	998 Julia	Yavelen Ran	dall				DMARII 40 D 180		

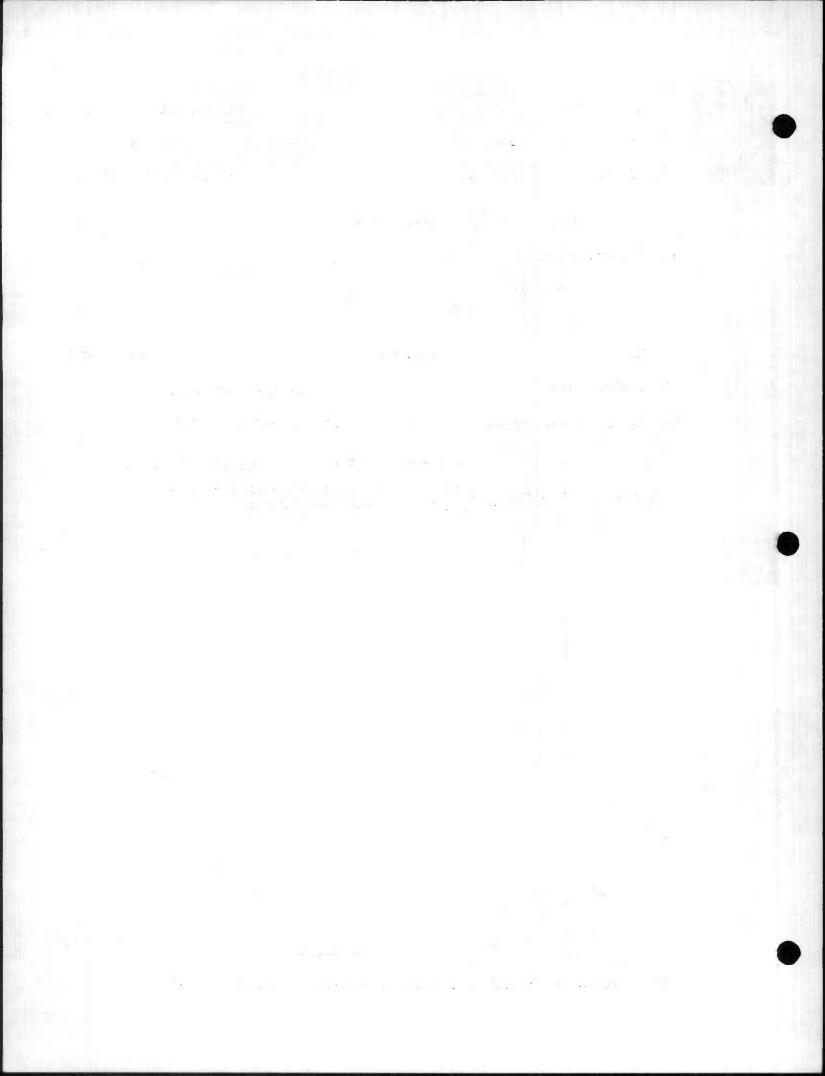


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State of Maryland / Department of Health and Mental Hygiene

			****						Death		Reg. No.)	UHJ	
Physi	cian	Decedant's Nama (First, Mana)								2. Data of Da Month	Day	Yaar	3. Tima	of Death
/Med		Carl H. F.								Mar 17	* T		2:45	pm
Exam	iner	4a. Fecility Nama (If not instit			er)				4b. City, Town, or	Location of Daet	h 4c. Cour	ity of Deeth		
		12204 Bedfo					Miller	4 V	Cumberla		Alle	gany		
Funera Directo		5. Social Security Number 214-07-5878 Usual Rasidance of Decedar		x]M 2□ F	Aga (In yrs 80	: last birthday) Yrs.	Month	ar 1 Year S Days	If Under 24 Hrs Hours Min.	(Month, Da	rth ay, Year) 0, 1917	Cou	ntry)	a or Foreign
hend lend		10a. Stete 10b. Co			10c. C	ity, Town or Lo	cation						10d. Inside	City Limits
Mary Fed Bh	to	MD Alle	egany			Cumber	land					1	1 □ Ye	es 2 No
1 the	1 2	10e. Street and Number	J1				-	ip Code			10g. Citizan o	f Whet Cou	ntry?	
3a o	O	12204 Bedfor	d Roa	d NE				21502)		US	27		
deeti	Funeral Director	11. Marital Status		12. Was Deceda	nt Ever in l	U,S. 13.			L Hispanic Origin? (S an, Mexican, Puar	pecify Yas or No	- 14. R	ace - Amari		
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laryian 2 should be end Mental 8 marked o	L O	Karl Flette	rman						Estella	(Sweit	zer)			
Maryla d 2 should th end Mer 7 is marke traumatic	ľ	19e. Informant's Name/Relat	ionship (Ty	rpe, Print)		19b. Mailin	ng Addre	ss (Straat	and Number or R	ural Route Numb	er, City or Tow	n, Stata, Zij	Code)	
		Estella S. K	ing-d	aughter		RD	3 Во	x 32	4 Clearv	ille PA	15535			
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Demit. Peges 1 ar permit. Peges 1 ar Department of Hea Important: If Item; any Injury or other		21. Signetura of Funaral San	vice Licens	A	1//	22	Scar	rpell	ess of Facility Li Funera	l Home,		20000		
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ficate be expression of the burie	edical	Cause (Disaasa or Injury that Initiated avants	5)	Due to (or es a consaq	uanca of):				+		
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death cert	N/S			1								1		
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	o Be	examinar? 1 ☐ Yes 2 ☐ No	-	lospital: 1 ☐ Inpa	ationt 2	Jer/Outpatian	t 3 🗆 E	Oth	oor.	ath <i>(Check only c</i> Ioma 5 ☐ Resi		that (Casai	6.1	
Phys or this eral d	1	27. Manner of Death		28a. Date of Ir	njury	28b. Time of	-	28c. Injur Wor		28d. Dascribe			y)	
l or Attending I efter death. Director: After d in by the funer	ig	1 ☑Natural 5 ☐ Pa 2 ☐ Accidant thy	nding estigation	(Month, E	Day Year)	Injury	М		rk? Yas 2 □ No					
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Direct A in by	ent	4 ☐ Homicida Ga		building,	atc. (Space	ify)				City or To	wn, Stata)			
To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical 0	29a. Certifier 1 Cart (Check only one)	fying Phys	sfcian: To the best nar: On the basis and menner	of/examine	owladga, daath etion and/or inv	occurre estigetio	d at the tir	me, deta and place pinlon, daeth occu	, and due to the irred et tha tima,	ceuse(s) end r date and plece	menner as s	stated. the cause	9(s)
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THE RESERVE OF THE PERSON NAMED IN		Dr. Vikramac 31. Data filed (Month, Day, Y			922 strar's Sign		al H	rdums	y cumber	Tand MD	21202			
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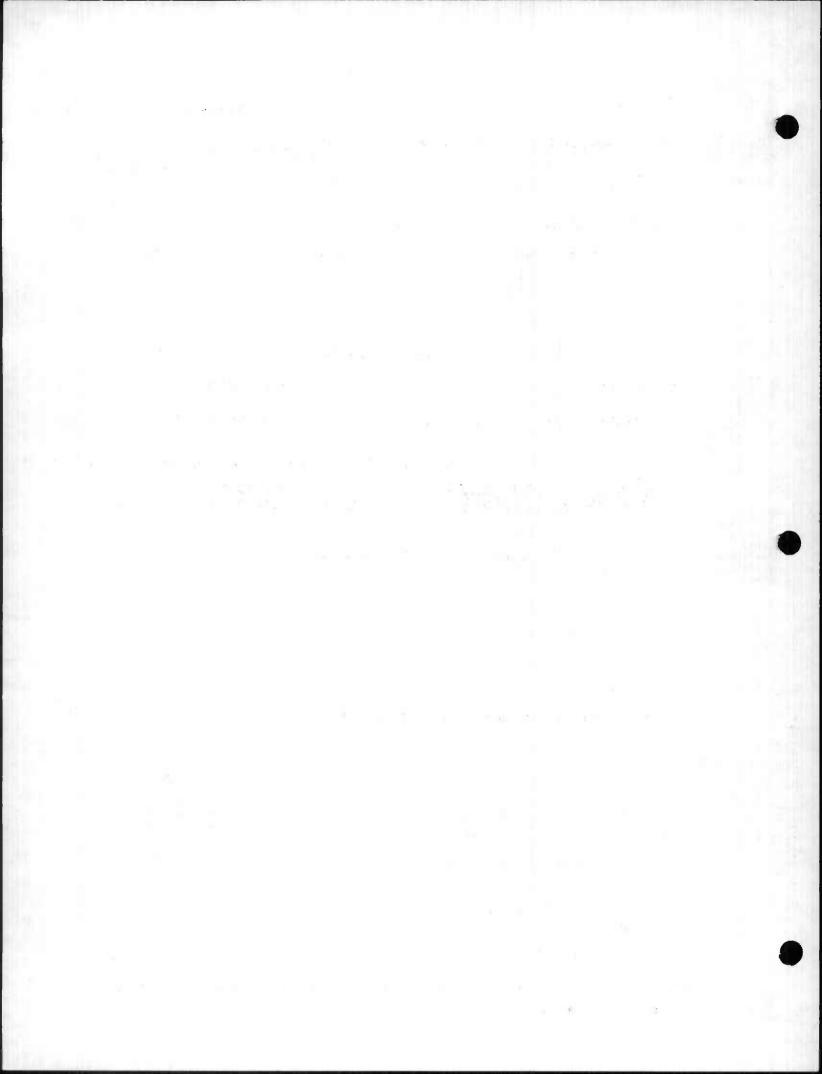
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	Ce	artment of Health and Me	Reg. No.	10432		
Physician /Medical	Decedent's Name (First, Middle, Last) JOHN LLOYD FARRIN	4	2. Dete of Deeth Month Dey March 15, 199	3. Time of Deeth 4:15 pm		
Examiner Funeral Director	4e. Fecility Neme (If not institution, give street and number) Memorial Hospital & Medical Center 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday, Yrs.) 217-10-1297	Months Devs Hours Min.	ation of Deeth 4c. County of	f Deeth		
e Maryland 8a-f show offied at	Usual Residence of Decadent 10a. State 10b. County 10c. City, Town or L MARYLAND ALLEGANY CUMBERLA			10d. Inside City Limit		
th with the Ma 23s or 28s-fs at be notified al Director	10e. Streat end Number 1506 C OLDTOWNE MANOR	10f. Zip Code 21502	10g. Citizen of Wh	•		
n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show heldel Exercite must be notified at leted by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowad 4 Divorcad 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes 2 No If Yes, Give Yeer or Detes:	Was Dacedant of Hispanic Origin? (Specify Specify Cuben, Mexican, Puerto Ri		- Amarican Indien, White, etc. WHITE		
than than complete Man	(Specity only highest grede completed) (Given Elementary/Secondery (0-12) College (1-4or 5+)	ident's Usuel Occupetion be kind of work done during most of working DO NOT use retired) ORDEN COMPANY	16b. Kind of Bus	Business/Industry		
d out H	17. Fether's Neme (First, Middle, Last) EDWARD FARRIN		First, Middle, Maiden Surname ENTINE)		
1 and 2 sho Health and em 27 is me ther traums			UMBERLAND MARY	RLAND MARYLAND 21502		
permit. Pages 1 and 2 should Department of Health and Men Important: If flem 27 is marke any injury or other traumatic office. To	1 M Buriei 2 Cremetion 3 Ramoval from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licansee	METERY MARCH 18 19 2. Name end Address of Facility IERRITT-ADAMS FUNERA 404 DECATUR STREET (998 CUMBERLAN	ND MARYLAND		
daath certificate be executed e attending physician and extremely dor use as the burial-transit sician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial Due to (or es e conse b. Due to (or es a conse The cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest a. Acute myocardial Due to (or es a conse c. Due to (or as e conse d.	quence of):		Intervel Between Onset and Deeth		
as that the di igned by the be detached by Physi	Pert II. Other significent conditions contributing to death but not resulting in the Congestive heart failure, diabetes		23b. Did tobacco use continuity 1 Yee 2 No 3	ribute to the cause of deat B Probably Unkno		
The law requires that sate has been signed by page 2 should be determined.			performed?	aveilable prior to completion of causa of death?		
trending Physician: death. ctor: After this certific y the funaral director fication: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No	Check only one) 5 Residence 6 Other d. Describe how injury occurred f. Location (Street and Number	(Specify)		
ne Hospital or A n 24 hours after ne Funeral Direction plataly filled in b edical Certil	29a. Certifier (Check only Medical Examinar: On the basis of exemination and/or in	h occurred et the time, dete end plece, en exestigation, in my opinion, deeth occurred	City or Town, State) d due to the ceuse(s) end maniet the time, date end place, er	ner as stated.		
	end manner steted. 29b. Signeture end title of cartifier	29c. License number	100,11110000000000000000000000000000000	(Month, Dey, Year)		
8	30. Name end eddress of person who completed cause of death (Item 23e) (Type,		March 16			
State Registrar	Sunil Gupta, M.D., Memorial Hospital 1 31. Dete filed (Month, Day, Year) 32. Registrar's Signature	medical Building, C	umperland, MD	21502		

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 15 1798 **Physician** March Alban T. Frye 06:42 AM /Medical 4c. County of Deeth
Allegany 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner Lonaconing Moran Manor 5. Sociel Security Number 214-07-3730 6. Sex M 2□ F If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 08-Oct-04 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Deys Hours 93 Maryland Yrs. Director Usuel Residence of Decadent death with the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Maryland Allegany Longconing 1 XYes 2 No Director 10e. Street end Number 46 Douglas Avenue 10f. Zip Code 10g. Citizen of Whet Country? 21539-U.S.A. Funeral 12. Wes Deceden! Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus permit. Peges 1 end 2 should be filed within 72 hours after to Department of Helelin and Mentel Hygiene.

Important: if flem 27 is marked other than "natural", or hanny Injury or other trainments. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes X No Specify: Specify:White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Service Department Textile Manufacturina 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be David Frve Isabella Naismith 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Nenhew William Frye 96 Washington Street Frostburg Maryland 21532-20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Frostburg Memoriai Park 17-Mar-98 Frostburg, Maryland 21. Signature of Funeral Service L 22. Name end Address of Fecility hu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Onsei and Deeth **Physician** my amtid Infarction /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner ettending physician and for use as the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? antry mises Completed 24e. Wes en eutopsy performed? peeu Pes 1 Yes 2500 1 ☐ Yes 2 ☐ No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) exeminer? Hospital: Other: 45 Yursing Home 5 Residence 8 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. injury et / Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide firstifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steled. Medicai 29a. Certifier one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 221444 3116/5 V 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Jesus H.Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532 TUS 32. Registrer's Signeture 31. Dete filed (Month, Day, Yeer) State MAR 1 6 1998 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FZANAGAN MARGARET ELIZABETH 0110am 4a Facility Name (If not institution, give street and number) FMERG DEPT. 4b. City, Town, or Location of Death 4c. County of Death COUNTY HOSP CARROLL 6EN'L WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) 1□M 2□F Yrs. 216-14-6114 Nov. 8,1906 Maryland Usuel Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 20 No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 200 Saint Luke Circle 21158 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Specify White 3℃Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 14 Teacher Education 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) William Starner Agnes Essick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2021 King James Parkway, Apt. 308 Westlake, OH 44145 Patricia Arthur/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Westminster Cem. 4 ☐ Donation 5 ☐ Other (Specify) 3/20/98 Westminster, MD 21. Signatura of Funeral Service Licenses 22. Nama and Address of Facility 91 Willis Street Myers Funeral Home Westminster, MD 21157 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, abock, or haert failure. List only one cause on each line. Approximete Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) PULMONARY EDEMA Due to (or as a consequence of) PNEOMONI Due to (or as a consequence of): 23b. Did tobacco uas contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? DIA387ES CORONDRY METERY BISSASS 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Hospital: 1 | Inpatient 2 | TER/Outpatient 3 | DOA | Other: 4 | Nursing Homa 5 | Residence 6 | Other (Specify)

/Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-tran

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Certification:

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Physician

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il Hygiene. other than "natural", or frama 23a or 28a-f ehow vent, ma Medical Evanther must be notified at

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Physician

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Director: Aft
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24 hours at re Funeral Di detaly filled in Hospital

within 24 ho To the Fune completely f

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediata causa. Enter Undarfying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I

CARERRO VASCULAR

25. Was cese referred to medical examiner? 1 Yes 2 No

27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending Investigation

28c. tnjury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

65'N'

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one)

1 Natural

2 Accident

3 Sulcida

4 ☐ Homicide

firstifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the causa(s) and manner as steted.

2 Medicat Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifler

6 Could not be determined

29c. Licensa number 1525203 29d. Data signed (Month, Day, Year)

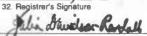
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memoziae Axe, MORROW

CARROLL COUNTY

Westminstermo 2115

State Registrar 31. Date filed (Month, Dey, Year)

MD



FLANAGAN, MARGARET ELIZAB FLANAGAN, MARGARET ELIZAB 11/08/1906 F 03/17/90

American Wagners

			Decedent's Name (First, Middle, La		aryland / De C	ertificat			2. Date of De	Reg. No.	8 1	3. Time of Death
	Physici /Medi			ROY JAME	S FRITZ				MARCH	15, 19	998	11:55 AM
S	Examir		4a. Facility Name (If not institution, glv. 93 BOND ST.	re street and number)			W	ESTMI		CAR	y of Death	
	Funeral Director			Sex 7. Ag	e (In yrs. last birthda 78 Yrs.	Months		If Under 24 H	Hrs. 8. Dete of Bir (Month, De	th by, Year) 1920	9. Birth Cou MAR	place (State or Foreign ntry) YLAND
	e Merylend ta-f ehow tried at	ctor	MD. 10b. County CARROL	L	10c. City, Town or WESTN	Location IINSTI	ER					10d. Inside City Limits 1 ☐ Yas 2X No
	th with th	Funeral Director	10e. Street and Number 93 BOND ST.			10f. Zip	Code 1 1 5 7	7		10g. Citizen of USA		ntry?
020	a within 72 hours efter deeth with the Meryland jene. r than "naturel", or items 23s or 28s-4 show the Medical Examiner must be notified at	þ	11. Meritel Stetus 1 Never Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 X Yes 2 I If Yes, Give Year or Detes:		3. Was Deced If Yes, spec	cify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No uerto Rican, etc.)	Bla	ce - Ameri ack, White, fy: WH]	
1215-0	vithin 72 ho ne. han "natur ne Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondery (0-12)		(Gi	. DO NOT u	rk done d se retired	during most of		16b. Kind of E		
Maryland 21215-0020	be filed tel Hygid d other event, I	To Be Co	11 17. Fether's Name (First, Middle, Last JAME		ON FRITZ		rity		d Name <i>(First, Middle,</i> Y BELLE			T
lary	2 should end Men le marke	-	19a. Informant's Name/Reletionship ((Street		Rural Route Numb		, State, Zij	o Code)
ore, N	Pages 1 end 3 nent of Health int: If Itam 27 I		SALLIE M. FRIT 20e. Method of Disposition 1 Burial 2 Cremation 3		20b. Piece of Dis	position (Nar	ne of	ce)	PAINSTER Date	20c. Location	- City or To	own, State
Baltimore,	permit. Page: Department or important: If i any injury or once.		4 Donation 5 Other (Special 21. Signeture of Factorial Service Licentary)	• •		22. Name en	d Addre	ss of Facility	3/19/98 FLETCHER , WESTM	FUNER	RAL H	
			23a. Pert1. Enter the disease, or comshock, or heart failure. List only	one cause on each li	ne.		•					Approximate Intervel Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Finei disease or condition resulting in death)	a. I.	schei	nic	+	Heav	+ 0	1500	se	10yrs
	uted d ansit	Examiner			Due to (or as a cons	Clia	(I	ntava	4,00	7	Zuts
68760,	certificate be assecuted ding physician and use as the burial-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	. Ve	MTVICO Due to (or as a cons	plai	. /	F, 6%,	Mati	010	1	SMIL
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s, P.O.	that the cled by the detached	by Physi	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying c	ause giv	en in Part I.		Yes 2 No		o the cause of death?
Records	aw requii ts been s 2 should	Completed b		_			_			an autopsy ormed?	94	Vere autopsy findings velleble prior to pumpletion of cause death?
Vital	The safe		25. Wes case referred to medical					OP Diese of I	1 🗆	W I TO THE	1	☐ Yes 2☐ No
of <	5 0	To Be	examiner? 1 ☐ Yes	Hospitel: 1 ☐ Inpatie	ent 2 ER/Output	ient 30 D0	Oth	er:	Death (Check only of Home 5 12 Residue)		her (Speci	fy)
ono	After fune		27. Nanner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry y Year) 28b. Time Injury	of 2	8c. injur Worl 1 □	yat k? Yes 2 □ No	28d. Describe	how injury occu	rred	
Division	the Hospital or Attend hin 24 hours after deeth the Funeral Director: mpletaly filled in by the	Certification:	3 Suicide 6 Could not b determined	28e. Place of Inj building, etc	ury - At home, farm, c. (Specify)	street, factory	, office		28f. Location (City or To	Street and Num wn, State)	ber or Run	al Route Number,
	the Hospital or after the Z4 hours after the Funeral Direct mpletaly filled in the zero control of the zero control of the zero control of zer	edical (29e. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of the be	examination and/or	ath occurred investigation	at the tin , in my o	ne, dete and pla plnion, death o	ace, and due to the ccurred at the time,	cause(s) and m date end place	anner as s	stated. o the cause(s)

To the Hospital or A within 24 hours after To the Funeral Directompletally filled in by

City or Town, State) building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

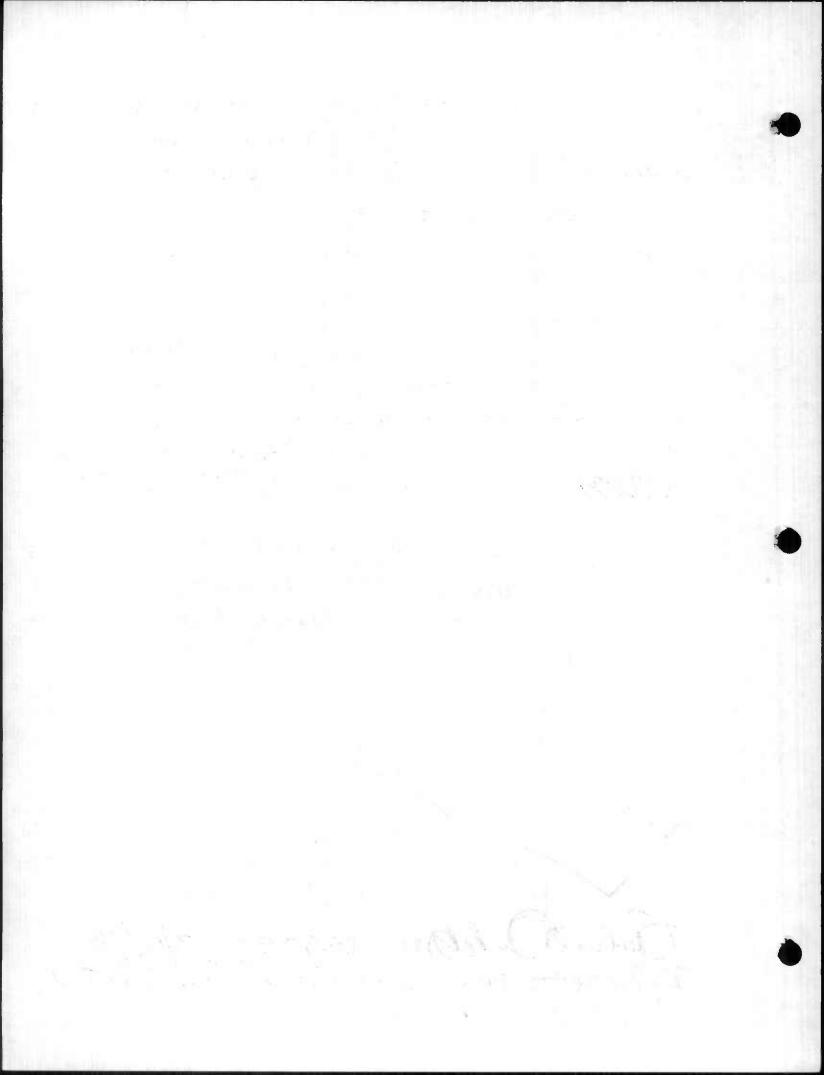
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
3/17/58 29c. License number

30. Neige and address of person who RICICITET
31. Date filed (Month, Day, Year) completed cause of death (item 23a) (Type,

MAR 1 9 1998

29b. Signature

39. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** MariLou H. Fitzpatrick Month 1998 2:00 PM March /Medical 4a. Facility Name (If not institution, give street end number) 4h City Town or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Stete or Foreign Country)
D.C. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□ M 2区 F Vrs 61 Director 206-28-9126 March 29,1936 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1X Yes 2 □ No Director Salisbury Md. Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21804 1010 Beaglin Park Drive, #204 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 1 No it Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elementary/Secondary (0-12) Chamber of Commerce Secretary 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumema) Miriam McIlvanie J. Edward Howard 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1010 Beaglin Park Drive, #204, Salisbury, Md.21804 John T. Fitzpatrick- Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify) Entombment Wicomico Memorial Park 3/20/98 Salisbury, MD. Bounds Funeral Home, 705 E. Main St., Salisbury, Md.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Physician /Medicai Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Chronic Obstructure Primany Yss 2□ No 3□ Probably 4□ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was an autopay performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 15 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the causa(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) bapel 16 98 morn D02026 30. Name and addrass of person who completed causa of death (light 23a) (Type, Print) F.G. Arthes, MD 31. Date tiled (Month, Dey, Year) 1622A Ocean Pines, Berlin, Md. 21811 32. Registrer's Signature

State Registrar

the Meryland

72 hours efter

Baltimore, Maryland 21215-0020

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tem 27 ie marked other than "natural", or items 23a or 28a-f ehow other treumstic event, tre Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 ie merked other than *n any Injury or other treumatic avant

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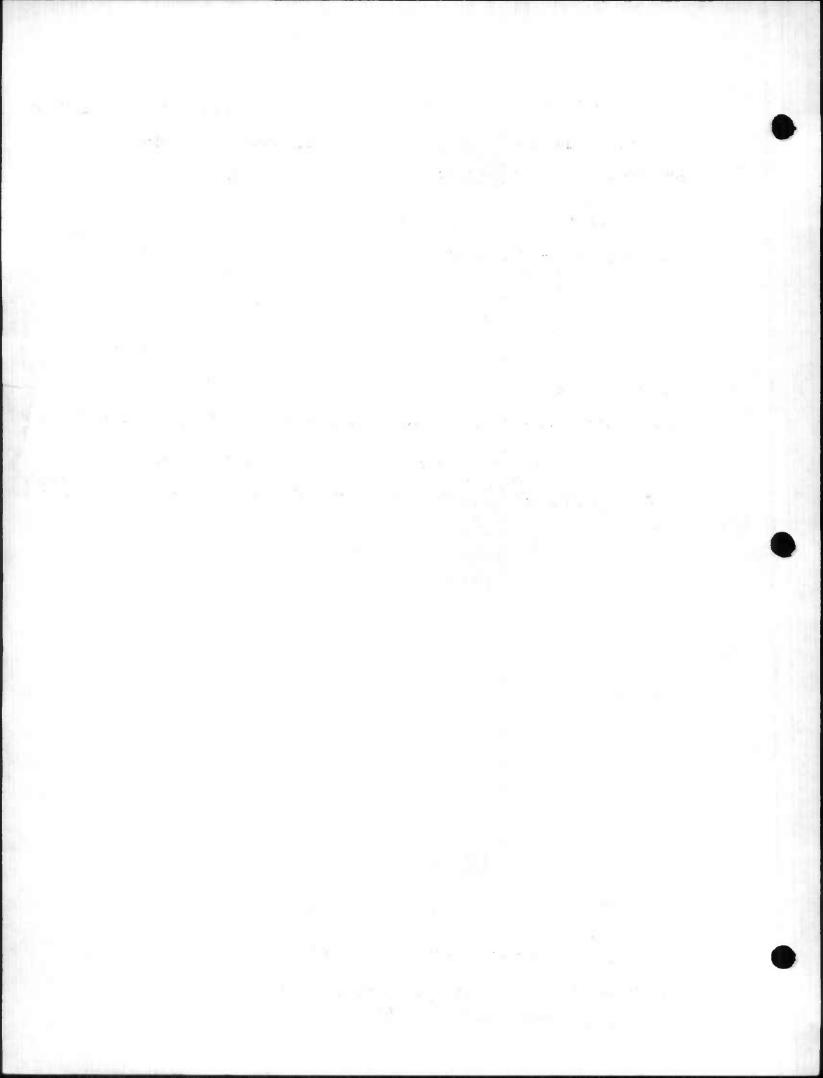
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To the Funeral Director: After this certifica completely filled in by the funeral director; s

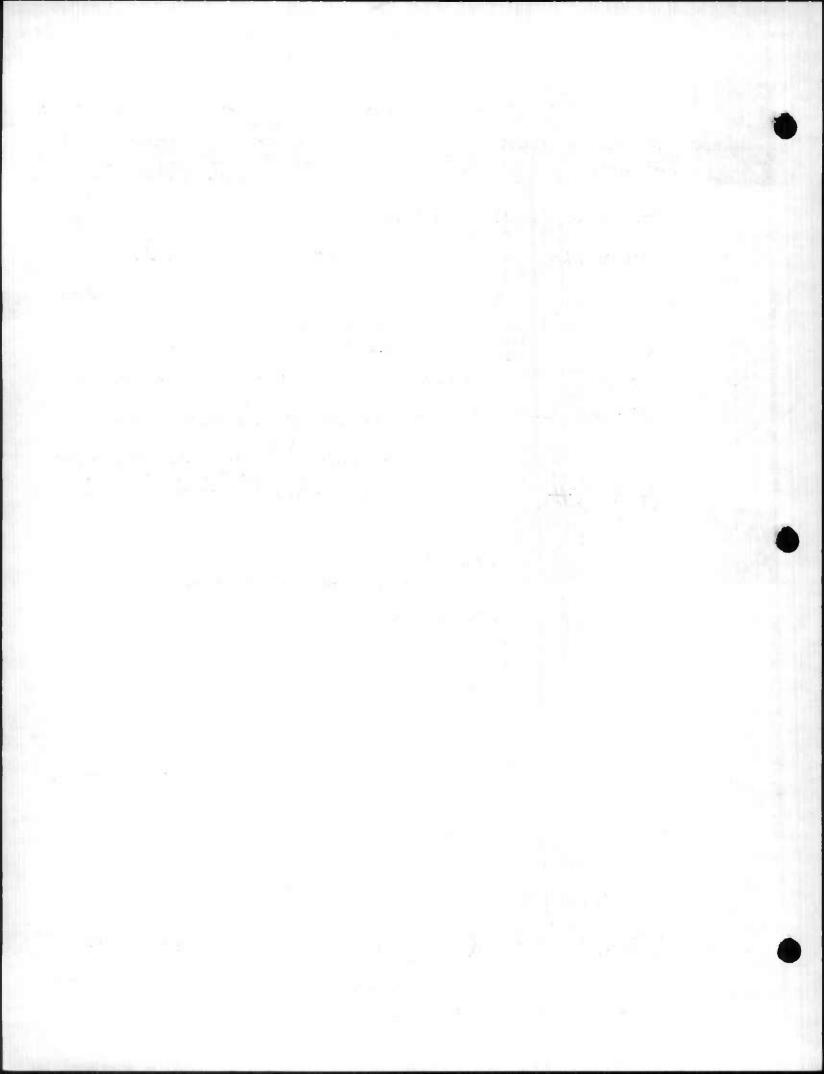
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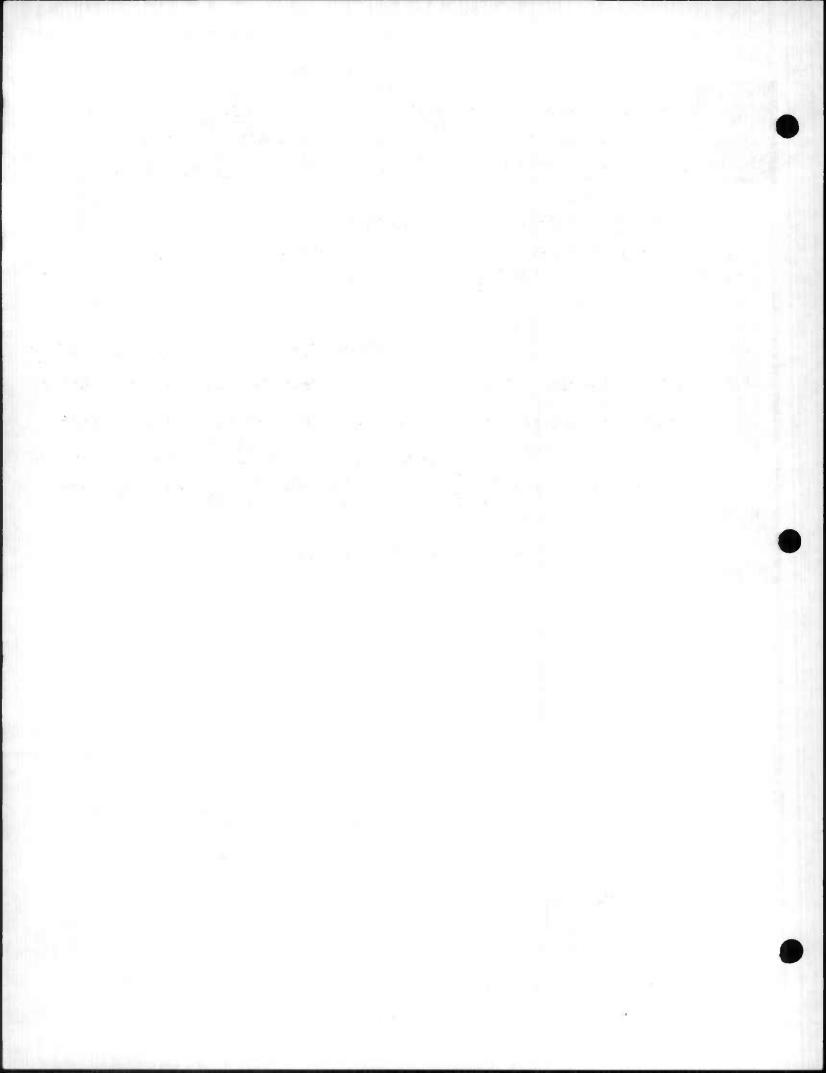


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hysici	an					0			Month	Dey	Yeer	Time of Death
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uneral rector	П		. Sex 7. A	ge (In yrs. 74	last birthe Yr	Month	er 1 Year s Deys	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D		9. Birthplece Country)	(Stete or Fore
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POTE POTE	Director	10e. Street and Number					ip Code			10g. Citizen of	Whet Country's	
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ten 21 is marked outs than returns, or tena 23s or 20st shoot other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Merried 2 Married Widowed 4 Divorced	12. Wes Deceder Armed Forces	.? ₩0	,S.			ispenic Orlgin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		ce - American leck, White, etc.	
dical Exp	eted	15. Decedent's (Specify only highest)	Education		16e. D	ecedent's Us	uel Occup	ion 16b. Kind of Business/Industry			ry	
The Max	Completed	Elementery/Secondary (0-12) 7th	College (1-4o	5+)	, i	Homen	use retired	1)		Hame		
raumatic evant, the Me	To Be	17. Fether's Name (First, Middle, La Joseph		nelot	ti			18. Mother's Nam Lena		Mazzc		
27 is mer traume		19e. Informent's Neme/Reletionship Michael Hayden G	(Type, Print) raves (Son)				end Number or Rui Lane Oc				de)
= ö		20e. Method of Disposition 1 ABurlal 2 Cremetion 3 4 Donetion 5 Other (Spe		3		isposition (A cremetory o Hill (25°, 1998		- City or Town, and, Mai	
any injury		21. Signeture of Funeral Service Lic			ALL.	22. Name	end Addres		ee Fune	eral Hom	e, Inc.	
ician dical niner	er	23e. Pert1. Enter the disease, or co shock, or heart feilure. List on Immediate Cause (Final disease or condition resulting in deeth)	e. Rej	nal F	ailu oreseco	re nsequence o	f):				Or	set end Deeth
transit	Examiner	Sequentially list conditions,	Due to (or es e consequence of):									
s the bunal-transit	edical E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events	c	cDue to (or es e consequence of):								
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ned by the atte	Physician/M	Pert II. Other eignificent conditione							23b. Dld	3b. Did tobacco use contribute to the cause of de		
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State of Maryland / Department of Health and Mental Hygiene

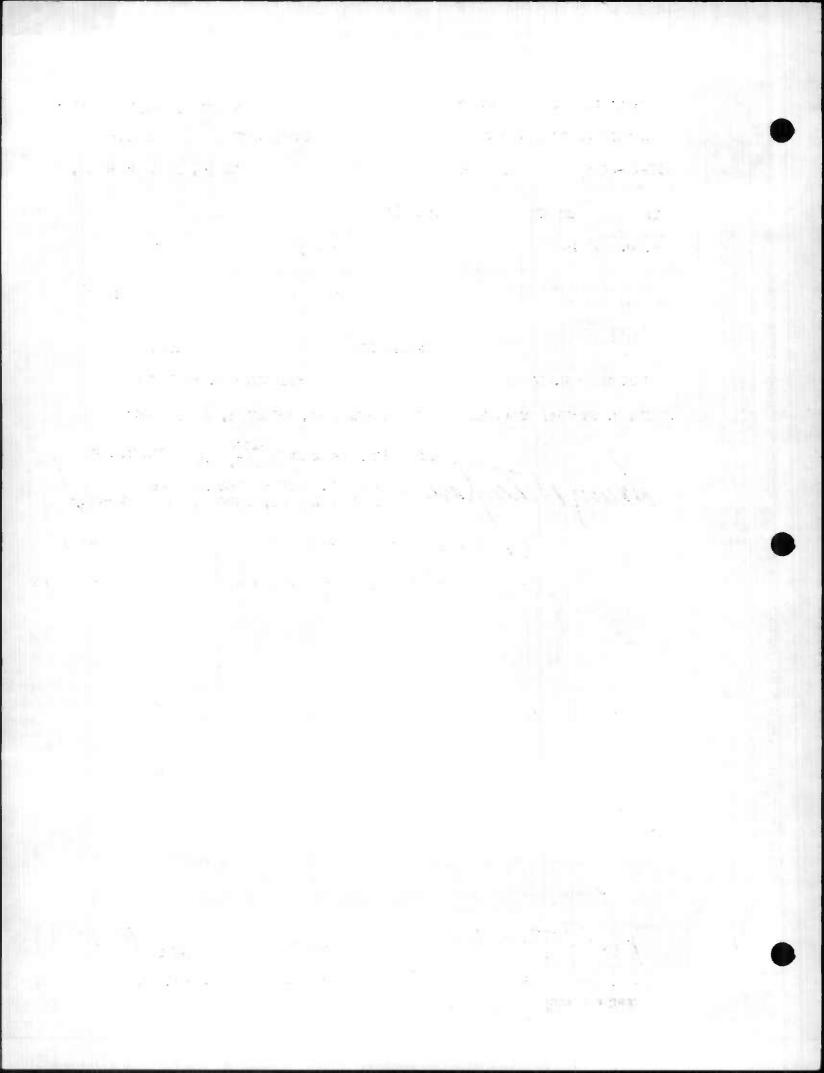
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Leonard 1998 /Medical FRANK MARCH GILROY 22 10:29pm 4e. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9575 TONY PLACE LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign Country)
Sept. 24, 1910 Maryland 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2□ F Yrs. 217-09-1923 87 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be nothing at 1 ☐ Yes 2 X No Director Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9575 Tony Place 20646 U.S.A. deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 end 2 should be filled within 72 hours effer or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinat 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bailiff/Builder Judicial/Building 6 18. Mother's Name (First, Middla, Maiden Surnama) 17. Fether's Neme (First, Middla, Last) Be William Merrick Gilrov Mary Virginia Henderson Gilroy 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 5340 Shady Oak Lane La Plata, MD 20646 Trudy Monroe/Daughter 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, State 3-25-98 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nanjemoy Baptist Cemetery Nanjemoy, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility
Arehart-Echols Funeral Home, M00817 P.O. Box 567 La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Final PROSTATE CANCER WITH METASTASIS TO NECK disease or condition resulting in death) Examiner Due to (or as e consequenca of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): ettending physician for use as the burie Box 68760 Physician/Medical Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? The law requires that the rate has been signed by page 2 should be detect 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 70 1 Yes 2□ Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ■ Control of □Other (Specify) this. 27. Manner of Death
1. Patural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending PI
 24 hours efter death.
 Funeral Director: After the Certification: 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Routa Number City or Town, Stata) 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man D28352 MARCH 24, 1998 30. Name and address of person who completed cause of death (item 23a) (Type, Print) KRISHAN MATHUR, M.D., P. O. BOX 2729, LA PLATA, MD 20646 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State This Studen Re Registrar MAR 2 5 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARGARET HYATT IRENE 16:45 MARCH 15 1998 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) FEB 20, 1906 If Under 24 Hrs. If Undar 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 TF HYNDMAN, PA 217-28-0625 92 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Insida City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at HYNDMAN BEDFORD PA 1 ☐ Yes 2 X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23a or any injury or other treumatic event, the Modical Examinor must be no P. O. BOX 14 USA 15545 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE À 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 8 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surname) Be FREDERICK W. BRUCK PRISCILLA G. ALBRIGHT 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEILA N. STURBA/ DAUGHTER RT 2, BOX 126B, BERKELEY, W VA 25411 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) MARCH 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata ALTOONA, PA ALTOONA AREA CREMATORY 4 Donation /5 ☐ Other (Specify) 17, 1998 uneral Service Licens 22. Nama and Addrass of Facility HARVEY H. ZEIGLER FUNERAL HOME 169 CLARENCE ST, HYNDMAN, PA 15545-0636, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate the control of the con Approximete Interval Between Onset and Deeth Physician Cerebrovasehler Accident /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Vascular Disease Athero Sclevotic 50 Years Examiner Copenan physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by the 1 Yes 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, i 25. Was cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No ပ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending Invastigation 1 ☐ Yes 2 Accident in 24 hour. the Funeral Director in the Funeral Direct 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1st Cartifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical To the Hosp within 24 hou-To the Fune completely fi 29d. Data signed, (Month, Day, Year) 29b. Signature and title of certific 29c. Licansa number MARCH who completed ceuse of death (Item 23e) (Type, Print), Inski M.D Seton 925 Registrar's Signeture State Registrar



ne Hospital or Attend n 24 hours efter death he Funeral Director: / To the Hosp within 24 hor To the Fune completaly fi

> wifes Alen 31. Data filad (Month, Day, Year)

29b. Signature and title of certifie

(Check only one)

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) end menner steted. 29c, Licanse number

29d. Data signed (Month, Dey, Year)

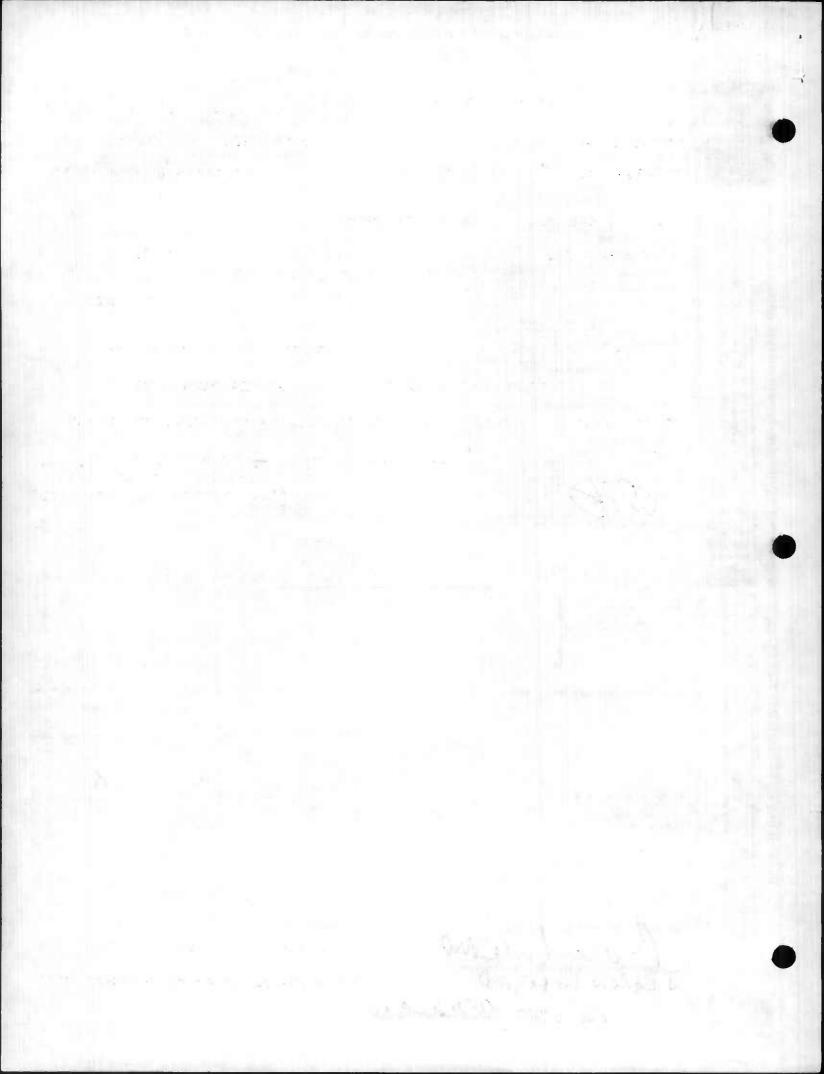
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complated cause of death (Itam 23a) (Type, Print)

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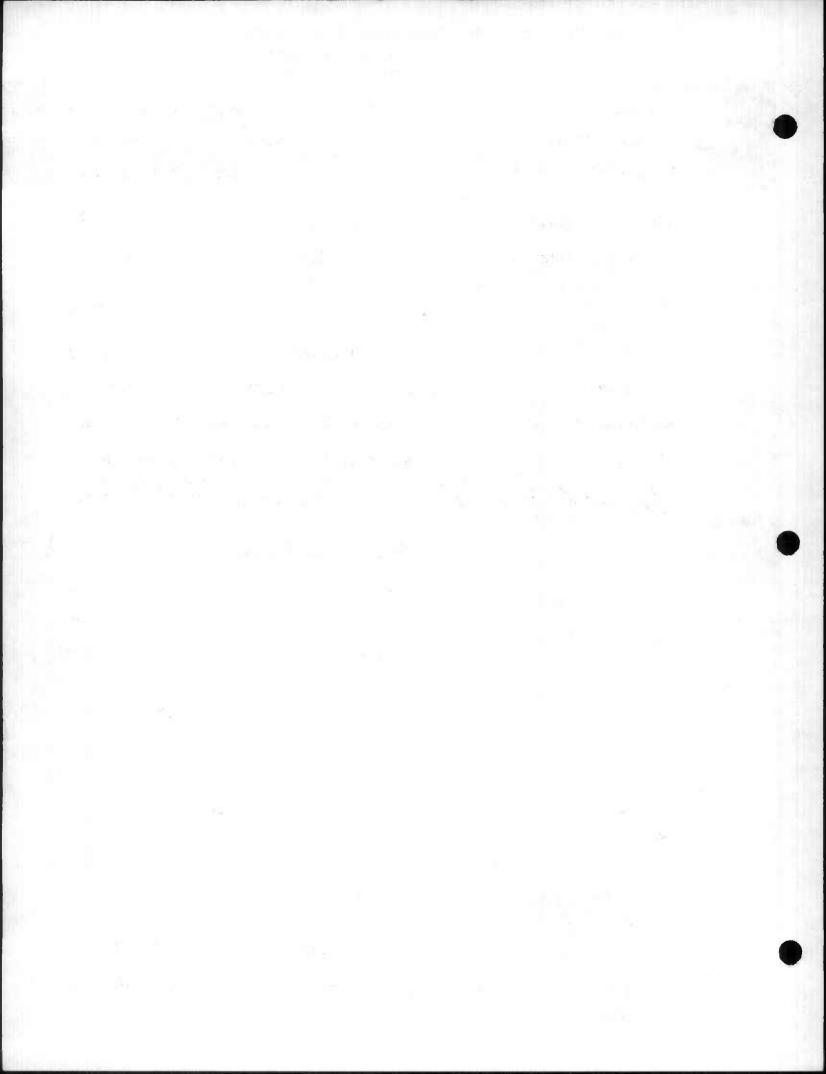
111 Penn Street, Baltimore, Maryland 21201

Registrar



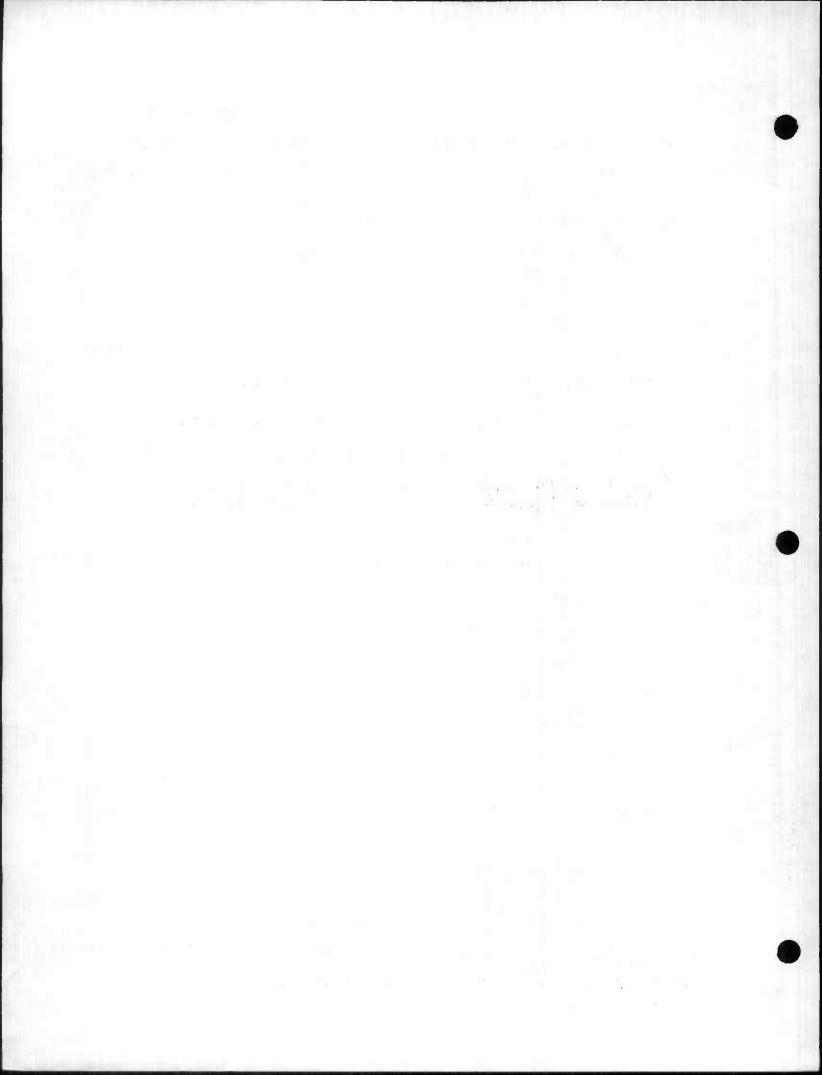
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	iviaiyia		tificate o			, ,	leg. No.	8 1	0441
	Physic	an	1. Decedent's Name (First, Mid	dle, Last)						2. Date of Dea	ith Dey	Yeer	3. Time of Death
-	/Medi	cai	DOROTHY 4a. Fecility Name (If not institute	on nive	H .			HARRI		v Town or Lo	MARCH cation of Death	12 1	998	4:55 P.M
M	Exami	ier	305 LILL		ST.				10.00	HEBRO		1	COMIC	0
	Funeral		5. Social Security Number	6. Se		7. Age (In yr.	s. lest birthday)	If Under 1 Ye		nder 24 Hrs.	8. Date of Birtl (Month, Day			-
L	Director		212-10-2691 Usual Residence of Decedent	1[]M 2∏F	81	Yrs.	Months Dey	s Ho	urs Min.	SEPT . 26	, Year) 5,1916	MAR'	ace (State or Foreign try) Y LAND
	aryland show		10a. State 10b. Coun	ty		10c. C	City, Town or Lo	cation					10	Od. Inside City Limits
	with the Maryla a or 28a-f show the notified at	Director		WICC	MICO			HEB	RON					1 X Yes 2 No
	毎 8 関	듬	10e. Street end Number					10f. Zlp Code				10g. Citizen of	What Count	ry?
	£ 22 H	E		LIAN	ST.				218			U.S		
020	urs after dea af, or items Examiner m	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce		12. Was Deced Armed Ford 1 Yes : If Yes, Give Year or Da	ces? 2 🔯 No		Vas Decedent of Yes, specify Ci I□Yes 2∑N			cify Yes or No- Rican, etc.)	14. Rei Bla Specil	ce - America ck, White, e	
9	72 houn natural, dical Ex		15. Decede	nt's Edu	cation		16a. Deced	ient's Usual Occ	upation			16b. Kind of B		
Maryland 21215-0020	i within 7 iene. than 'n	Completed	(Specify only high Elementary/Secondery (0-12)	1	e completed) College (1-	4or 5+)	(Give life. L	kind of work dor OO NOT use reti	red)		ng	CHIE	m EAG	mony.
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an	Ald be Alental riced o	o Be	HULBERT				HOOK			ALICI			MOORE	
7	should nd Mer marks marks	To	19a. Informant's Neme/Relation	ship (T	me. Pnint)		1	g Address (Stre	et end N					Code)
M	transition of the second		DONALD HARRIS				315			TERRACI		SBURY.		1804
e,	Hoa H		20a. Method of Disposition		ON	20b.	Place of Dispo	sition (Name of		TERRACI	Date	20c. Location		
Baltimore,	8-2 = 8		1 Burial 2 □ Cremetion 4 □ Donetion 5 □ Other			tate		CEMETE		3-	16-98	HEBRO		
Ball	permit. Pa Departmen Important: any injury otice.		21. Signature of Funeral Service	e Licens	800	2		. Name and Add				D5 E. M ALISBUR		
	de l		23a Part . Enter the diseese, shock, or heart failure. Li	or compl st only or	ications that ca ne cause on ea	used the dea ch line.		BOUNDS or the mode of d			-			Approximate Intervel Between Onset and Death
	Physician /Medicai		Immediete Cause (Final disease or condition				A	infe k	evul	Feirla	e			325
L	Examiner	Jer	resulting In death)	•	a	Due to	(or as a conseq							
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68760,	nta be nysicii	edical	Cause (Diseese or injury thet initieted events resulting in death) Last	S ')	Due to ((or as a conseq						+	
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D. Box	e deeth carti the attending hed for usa a	Physician/N	Part II. Other algnificant condit	ions cor	ntributing to dea	ith but not re	esulting in the ur	nderlying cause	given In I	Part I.	23b. Dld t	obacco use co	entribute to	the cause of death?
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of Vital	delan: The certificate rector, pag	BeC	25. Wes case referred to medic	al					26.	Place of Deeth	(Check only or	(1001120110
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 254No	F	fospital:	patient 2[☐ ER/Outpatien	1 3□ DOA	Wher		ne 5 Resid		ner (Specify)
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Division	or Attan after dea Director	Certification:	3 Suicide 6 Could		28e. Plece o	of Injury - At I	home, farm, stre cify)	et, factory, offic	9	2	8f. Location (S City or Tow	treet and Numi n, Stete)	ber or Rural	Route Number,
	To the Hospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Mertica	ng Proye	clan: To the b	est of my kn	nowledge, death netion end/or inv	occurred at the	time, da	te end place, a	nd due to the d	ause(s) and m lete and plece,	anner as sta	ated. the cause(s)
	ithin o the	M	29b. Signature and title of certific	1	and manne	or stated.		29c. Lice	nse num	ber		29d. Date signe	ed (Month, D	Dav. Year)
	F 3 F 8		• (/	V)	V.			501			3/13	199	
		1	30. Neme and address of person	-	,	-				51 -	0:-1		115	
		C	Unristopher S	. SV	yder,	D.O.	nature Ax-Rardal	ine Bl	uff	Kel 8	sel 100	ury	MD	21801
	Sta		31. Dete filed (Month, Day, Yea	100	32 Re	gistrer's Sign	nature Park	L				1		
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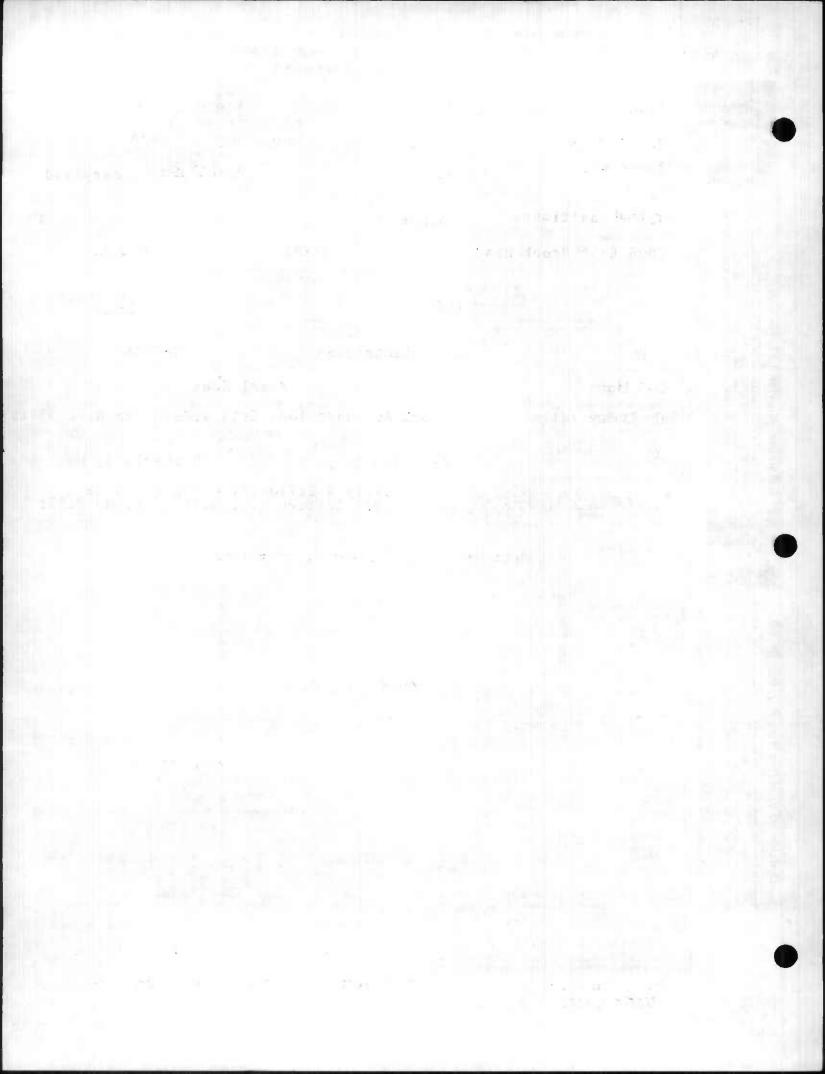


State of Maryland / Department of Health and Mental Hygiene

Physic /Med Exami Funeral Director	ical	Dorothy ELEANOR								Time a of Death
Funera Director			KALBAUGH				2. Date of Do Month	Day	Year	Time of Deeth
Funeral Director	itei	4a. Facility Name (If not institution, give				4b. City, Town, or I	March Location of Deal			9:40 am
Director		Memorial Hospital		nter		Cumber1ar		Allega		
ъ.		5. Social Security Number 220–10–7655 6. Se		lest birthday) If (Under 1 Year nths Days	If Under 24 Hrs.	8. Date of Bi (Month, Di JAN 21	rth ay, Year)		(State or Foreign
(d)		Usual Residenca of Decedent 10e. State 10b. County	10c. Cit	y, Town or Location	n				10d Je	slde Clty Limits
daryis f aho	ō	MARYLAND ALLEG		UMBERLANI						Yes X No
th with the Maryland 23a or 28a-f ahow	al Direct	10e. Street and Number 12005 AMBER DRIV			of. Zip Code	21502		10g. Citizen of V		
er dea	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3XXWidowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2√ No If Yes, Give A Yeer or Detes:		Decedent of I , specify Cub es 2/ No	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Ricen, etc.)	o- 14. Rac Blac Specify	e - American Inck, White, etc.	
21215-0020 d within 72 hours aff jiene. r then "netural", or the Wedical Example.	Be Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation e completed) College (1-4or 5+)		Usual Occup of work done OT use retire E KEEP	pation o during most of wor ed)	king		usiness/Industry	
S S S S	To Be Co	11 17. Father's Name (First, Middle, Last) CHESTER MEADE FI	LES			18. Mother's Nan	ne (First, Middle RENE WO	o, Malden Suman DLFORD	ne)	
aryla should and Men s marks		19a. Informant's Name/Reletionship (T)	rpe, Print)	19b. Mailing Ad	idress (Stree	t and Number or Ru	ral Route Numb	per, City or Town,	Stete, Zip Code	9)
and 2.		DONNA ADAMS	DAUGHTER	RFD# 1		63AAA HY	'NDMAN,		545	
Baltimore, permit. Pages 1 and Dependent of Healt Important: if item 2: any injury or other		20a. Method of Disposition 1 Burial 2XX remation 3 F 4 Donation 5 Other (Specify)	Removal from State	Plece of Disposition emetery, cremator BERLAND	y or other ple	ORY MARCH	Date I 18 199		City or Town, S RLAND M	
Ball permit Depend Import		21. Signature of Funeral Service Licens	erutt	MERR	ITT-AD	ess of Facility AMS FUNER IR STREET			YI.AND	
THE PARTY NAMED IN		23a. Pert1. Enter the disease, or compleshock, or heart failure. List only or	idations that caused the deet ne cause on each line.	h. Do not enter the	mode of dyi	ing, such as cardiac	or respiratory	errest,	Appl	roximate val Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting In death)	Metastatic Due to (c	Carcinon						et end Death
ecuted end I-transit	amine	Sequentially list conditions,	Due to (o	r es a consequenc	e of):			_		
68760, rificete be executed g physician end es the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury the initialeted events resulting in death) Last	Due to (o	r es a consequence	e of):					
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O. B deat he ett	sicie	Pert II. Other aignificant conditions cor	ntributing to death but not res	ulting in the underly	ying ceuse gi	iven In Pert I.	23b. Did	tobacco use co	ntribute to the	cause of death?
cords, P.O. Box v requires that the death cer been signed by the ettendir should be deteched for use	by Phy			-	-		1 🗆	Yes 2□ No	3 Probably	4 Unknow
Vital Records, iclen: The law requires the certificate has been signe rector, page 2 should be control of the c	Completed						24a. Was perf	s an autopsy omned?	evelleble	utopsy findings a prior to ion of cause ?
al Rec							1 🗆	Yes 2 No	1 🗆 Yes	2 No
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655 on of fing Phys Affer this	on: To	1 Yes 2 TVNo 27. Manner of Death 1 Naturel 5 Pending	28a. Dete of Injury (Month, Day Year)	ER/Outpatient 3l 28b. Time of Injury	DOA 28c. Inju	4 LI Nursing H		Idence 6 Oth how Injury occur		
220-10-7655 Division of Vital Records, P.O. Box To the Hospital or Attanding Physician: The law requires that the death cer within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be deteched for use	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined	28e. Place of Injury - At he building etc. (Specif	ome, farm, straet, fo		Yes 2 No		(Street end Numb wn, State)	per or Rurel Rou	te Number,
220. Hospita 124 hours Funeral	edical C	29a. Certifier 157 Certifying Physical Control (Check only one)	alcian. To the lest of my kno ner: On the basis of examine and manner stated.	wledge, death occu tion end/or Investig	urred at the ti letion, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	ceuse(s) end ma , dete end plece,	anner es steted. end due to the o	ceuse(s)
To the To the	Me	29b. Signature and title of certifier	12		29c. Licen	se number		29d. Date signe	d (Month, Day,	Year)
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Mds		30. Neme and address of person who co				MD 21502				
	ate	Vik Poonai, M.D., 31. Data filed (Month, Day, Year)	922 National 922 National 923 Registrar's Signa		are,	MD 21502				



	Y Allegany C	/			Certific	cate o	f Death		Reg. No.	0 1	0443	
sician	1. Decedent's Name (First, Middle, Las	st)					2. Date of Month	Death Day	Year	3. Time of Dea	
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r is marked other traumatic event, in	Clark Lindsay Pearl Edna Tayl								24/02			
	19a. Informant's Nam Evelyn Linds			2	19b. Mailing Add 2453 Ave	dress (Stre	et end Number or	Este,	mber, City or To	Beac	zip Code) ch, FL 33	
Important: if Item 27 i any injury or other tr. DRCe.	20a. Method of Dispos	20b. Plac	ce of Disposition	(Neme of		Date			Town, State			
	1 Burial 2 0 4 Donation 5		_	emetery 3-18-98 cumberland					d, MD			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Vaa **Physician** Thelma Marle Layman 06:35 PM March 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Saint VIncent de Paul Nursing Center Frostburg 5. Social Sacurity Numbar If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 8. Data of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 □ M 2K0 F 213-10-7669 84 Yrs Director 14-Oct-13 Maryland Usuai Rasidence of Dacadant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Heelib and Mentel Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exprise man be notified at any Injury or other traumatic event, I'm Medical Exprise man be notified at 1 Yas 2 No Allegany Frostburg Maryland Directo 10e. Street and Number 1 2006 Upper George's Creek Road, \$.104, Zip Coda 10g. Citizan of What Country? 21532-U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 11. Marital Status 2 should be filed within 72 hours efter on and Mentel Hygiene.

Is marked other than "natural", or flee 1 ☐ Yas 2X No If Yas, Giva 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 □ Yas X No Specify:White à lf Yas, Giva Yaar or Datas: 3 Widowed 4 Divorced Completed 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Homemaker 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be William Lyons Amelia May Alexander P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Daughter **Barbara Stine** 10107 Silver Twine Lane Maryland 21046-Columbia 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State Frostburg Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) 19-Mar-98 Frostburg, Maryland 21. Signature of Funaral Sarvice Light 22. Nama and Addrass of Facility 11 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Dant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) lated Cardiomy opathy mo Examiner Examiner wo sician and burial-transit Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in daath) Last Due to (or as a consaguanca of): physician s the burial Melli Box 68760 siabotes Physician/Medical Dua to (or as a consequence of) 98 ettending 980 0 signed by the et d be detached fo Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. P.O. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? Completed been : has page 2 certificate 2 NO 1 Yas 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific 25. Was case rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospitai: Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 2 1 Yas 2 XNo 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Mannar of Death Certification: 28a. Data of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant the 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide cal 29a. Certifier 🔯 Certifying Phyatclen: To tha best of my knowladga, death occurred at tha tima, data and placa, end due to the causa(s) and mannar as stated. pletaly 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) wen 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

Angel H. Roque, M.D., Frostburg Community Center, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) 32 Registrar's Signatura State MAR 1 8 1998 Registrar

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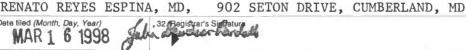
State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month Day Yaar **Physician** GRACE SYLVIA LOGUE MARCH 13, 1998 1814 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY 5 Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 1 ☐ M 2 💢 F 81 208-10-1184D Yrs. Director AUG 12, 1916 HYNDMAN, PA Usual Residence of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or Items 23s or 28s-f show trsumstic event, tre Modical Examiner must be notified at PA BEDFORD HYNDMAN 1XX as 2 □ No Director 10e. Street and Number 10f. Zio Coda 10g. Citizan of What Country? 2ND AVENUE 15545 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 22 DNo It Yas, Giva Yaar or Datas: 11. Marital Statua 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 2 should be filed within 72 hours efter or end Mental Hygiene.
Is marked other than "naturel; or iter 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2√ No Spacify: Specify: WHITE þ 30XWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT use retired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Coilega (1-4or 5+) HOMEMAKER HOME 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be LLOYD HUSTON ALBRIGHT GRACE SYLVIA MULLIN 2 19a. Informant's Name/Raietionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 Depertment of Health el Important: if Item 27 Is eny Injury or other trea BETH GLENCOE/ DAUGHTER R. D. 1, BOX 15, HYNDMAN, PA 15545 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Stata XXBurial 2 Cramation 3 Ramovai trom State HYNDMAN CEMETERY MAR 17, 1998 HYNDMAN, PA 15545 5 ☐ Other (Specife) 4 Donation Funeral Service 22. Nama and Addrass of Facility HARVEY H. ZEIGLER FUNERAL HOME 169 CLARENCE STREET, HYNDMAN, PA 15545-0636 ns that causad tha daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, usa on each line. Approximata Interval Batwean Onsat and Daath **Physician** /Medical Immadiata Cause (Finel ACUTE RESPIRATORY FAILURE DAYS disease or condition resulting in death) **Examiner** Dua to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE 10 YEARS sician end buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): be exec physician s the buriel Box 68760. Physician/Medical Dua to (or as a consequence of) 98 USB signed by the at d be detached for P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 No 3 Probably 4 Unknown NEUROMUSCULAR DISEASE Records. þ 24b. Wara autopsy findings available prior to 24a. Wes en eutopsy Completed peen PNEUMONITIS complation of cause of daath? The law After this certificete has page COMA 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was casa ratarred to medical 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 Anpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No 2 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima ot 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funerel Director: After Injury 1 Natural 2 Accidant 5 Panding 1 Yas 2 No invastigation by the 6 Could not ba 3 Sulcida 28a. Place of Injury - At homa, tarm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida edical Certifying Physician: To the bast of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar as stated.

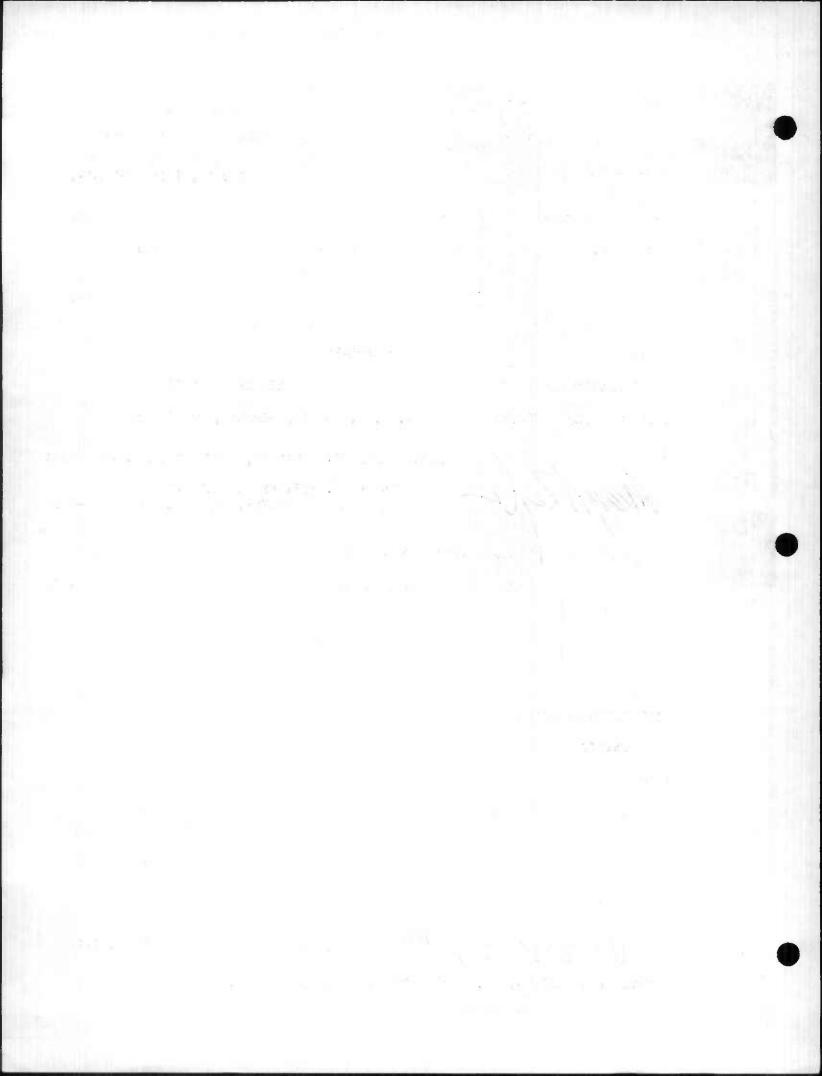
Madical Examiner: On the bast of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian 29b. Signatura and title of certities 29c. Licansa number 29d. Data signed (Month, Day, Yaar) D 03459 MARCH 14, 1998 30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print) MIS

State Registrar

31. Dete tiled (Month, Day, Year) MAR 1 6 1998



21502



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) Month Day **Physician** 29, 1998 7:30 p.m. Flarold A. Lloyd
4e Fecility Nama (If not institution, give street and number) March /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center

7. Aga (In yrs. last birthday)

Yrs. Annapolis Anne Arundel Anne Arundel 8. Deta of Birth (Month, Day, Year) Birthplaca (Steta or Foraign Country) 5. Social Security Number **Funeral** Min. Hours Months Deys **Director** 212-16-0001 May 20, 1919 Maryland Usuel Rasidenca of Dacedan the Maryland 10c. City. Town or Location 10d. Insida City Limits 10e. State 10b. County must be notified at 1 ☐ Yas 2 ☐ No Directo MD Queen Anne's Chester 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 2713 Cox Neck Rd. 21619 Funeral death 12. Wes Decedent Ever in U.S. Armed Forcas?

1 Yas 2 No If Yas, Giva Pages 1 and 2 should be filed within 72 hours aftar deat ent of Health and Mental hygiene. Int: If Item 27 Is marked other than "netural", or items into order transmits swent, its Medical Exemperator. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Yeer or Datas: white Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Elementery/Secondery (0-12) College (1-4or 5+) extior and interior designer self-employed

18. Mothar's Name (First, Middla, Maidan Surnema) 10 17. Fether's Nama (First, Middle, Last) Be Sophia J. Smith William L. Lloyd 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Geneva Lloyd, wife 2713 Cox Neck Rd., Chester, MD 21619

20b. Place of Disposition (Nama of cematary, crametory or other place)

Apr. 4 , 1998 Apr. 4 , 1998 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or gence. Chester, MD CHesapeake Cremation Ctr. 1998 Fellows, Helfenbein & Newnam 106 Shamrock Rd Chester, MD 21619 Approximeta Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Cerebro Vascular Accident disease or condition rasulting in deeth) Examiner lationant the death certificate be executed physician and s tha buriel-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that Initioted events rasulting in daath) Last 10 years Renal Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown obstruction requiring by 24b. Ware eutopsy findings evailable prior to Completed 24a. Was an autopsy lanuary completion of cause of death? 1 ☐ Yas 2 ☐ No 1 Yas 2 No Be 25. Wes case refarred to medical axaminar? 26. Piece of Deeth (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yas 2□ No 1 Inpatiant 10 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury at Work? 28b. Tima of Certification: or Attending Patter death.

Director: After t After 5 Pending Invastigation 1 Neturel 1 Yes 2 No 2 Accident the Funeral Direction of the Funeral Direction 6 Could not be datamined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and dua to the causa(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date and piece, and dua to the causa(s) and manner stated. 29a. Cartifian Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licanse number MI andara Lour 30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print)

Bestgate

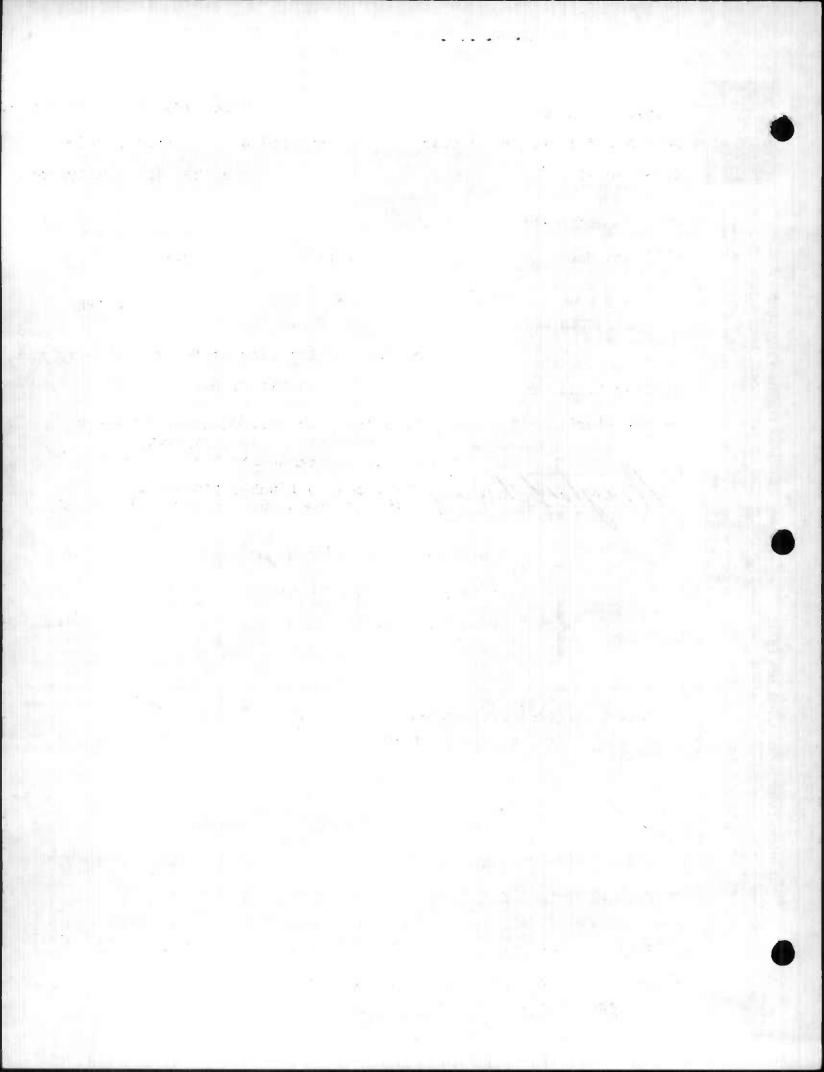
32. Régistrar's Signatura

wha Davidson

State Registrar 31. Date filed (Month, Day, Yeer)

APR - 1

1998



WRC 98-1577-003 DAVID A. LAMBERT

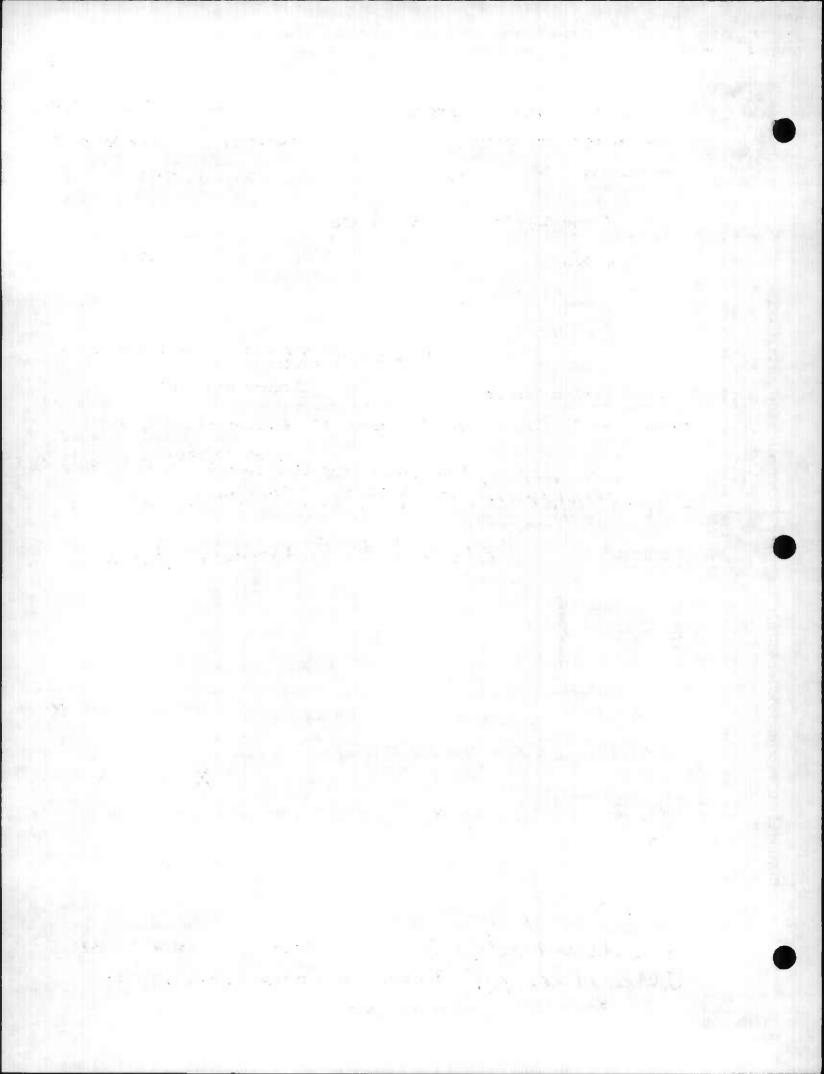
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State of Maryland / Department of Health and Mental Hygiene

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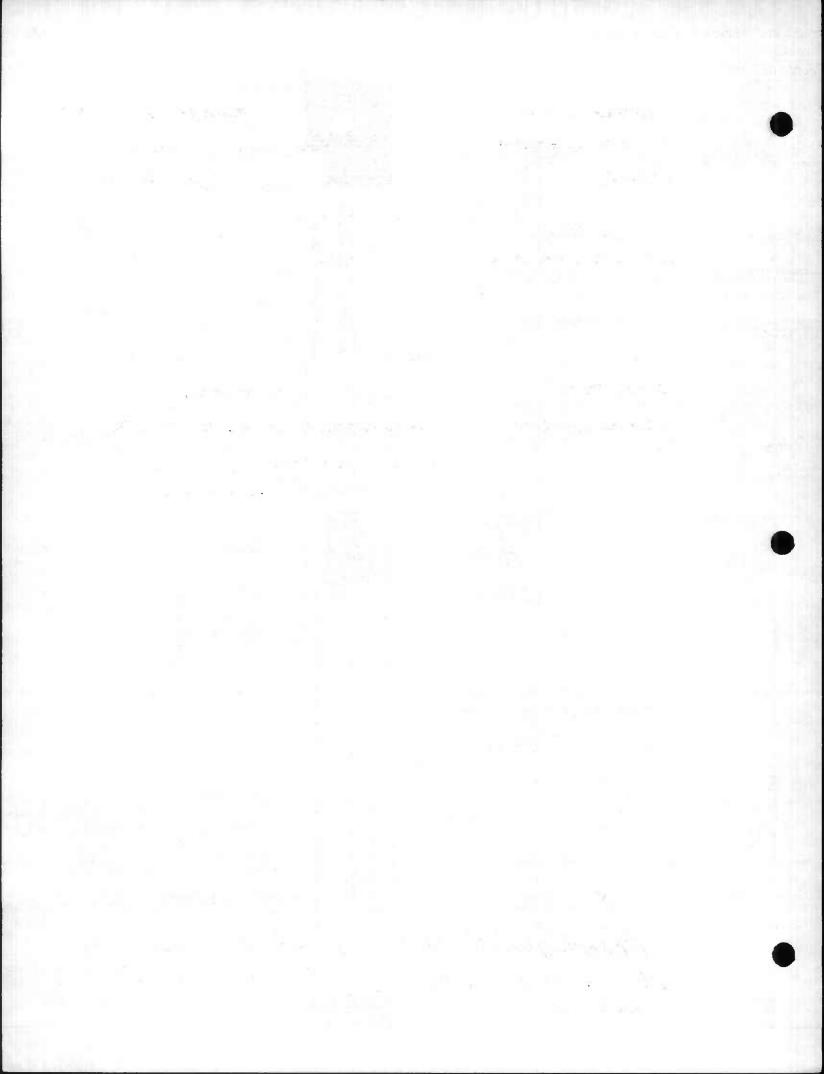
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State Registrar



State of Maryland / Department of Health and Mental Hygiene

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	Physic /Medi		Virgi	nia L. I	Martz						Dey 18, 1998		0719
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Division of	g Ph ler th		27. Manner of Deel		28a. Data of (Month	Injury Day Year	28b. Time of Injury	28c. Inju	iry at	28d. Describe	how Injury occurr	ed	
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			Decedent's Neme (First, M	iddle (set)		Ce	rtificate of	Death	2. Dete of D	Reg. No.		1449
	Physici		Mary Elizabet						Month	Dey	Yeer 1998	3. Time of Deeth
	/Medio		4e. Fecility Neme (If not institu		um <i>ber</i>)			4b. City, Town, or	March Location of Dee	th 4c. County		07,00 GIII
	Exami	iei	Sacred Heart H					Cumberlar			egany	
	Funeral Director		5. Social Security Number 213-22-4158	6. Sex 1 □ M 2 K F	7. Age (In yr. 73	s. lest birthdey) Yrs.	If Under 1 Yaa Months Dey			irth ley, Year) I-24	9. Birthple Count Marylo	eca (Stata or Foraig y) and
pue	*		Usuel Rasidence of Decedent 10a. Stete 10b. Cou		100 (City, Town or Lo	scation				10	d Incide City I Imite
Aenyle	Sile	P		Allegany		stburg	Cation				10	d. Inside City Limits 1 ☐ Yas 2 💆 No
the	289	Director				312019	10f. Zip Code			10g. Citizen of N	What Count	rv?
with	3ª or	O	10e. Street end Number 283	2 Pocanonia	s koda		215	32-		U.S.A.		,
d 2 should be filled within 72 hours after deeth with the Meryland	"natural", or items 23a or 28e-f show ad cal Examiner must be notified at	by Funeral	11. Marital Status 1 Naver Married 2 N 3 N Widowed 4 Divor	Armed F Married 1 Yes	2 X No		Was Decedant of If Yes, specify Cu 1 ☐ Yes 2X No	Hispenic Origin? (Span, Maxican, Puer Specify:	Specify Yes or N to Rican, etc.)		e - Americe ck, White, e	
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8 .	item 2		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetic 4 ☐ Donetion 5 ☐ Other		State	Plece of Dispo cometery, created	osition (Neme of metory or other pi	ace)	Dete	20c. Location -	City or Tow	n, Stete
permit. Page	Department of important: If any injury or once.		21. Signeture of Funeral Serv		rest	22	2. Name and Add					
			23 Part1. Enter the disease shock, or heart feilure.	, or complications that list only one cause on	ceused the de							Approximete Intervel Between
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cian	s certificate director, pag	Be	25. Wes cese referred to med exeminer?	Hospital:					ath (Check only	one)		
Attending Physician:	0 0	atlon: To	1 Yes 2 No 27. Menner of Deeth 1 Neture 5 Per 2 Accident	28e. Date	• • • • • • • • • • • • • • • • • • • •	28b. Time of Injury	28c. Inj		_	idence 8 Oth how injury occur		
5 4	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Cou	ermined 28e. Plea		eet, factory, office	1		(Street and Numb own, Stete)	per or Rural	Routa Number,	
he Hospit	within 24 hours a To the Funeral D completely filled	edical								and due to	eted. the ceuse(s)	
Tot	To t	Σ	29b. Signetura and title of con	fier 0 1 4 m	200		29c. Licar	sa number		29d. Data signe	d (Month, D	lay, Year)
	5			wellor	M	0	"D	13/66		March	18.	1998
_	nes		30. Name and address of pers	on who completed ceu le, M.D., 48 To	ise of deeth (Ite Irn Terrac	en 23e) (Type,	Print) Urg, Marylo	ind 21532				
	Sta	te ar	31. Dete filed (Month, Dey, Ye	1998	Registrer's Sign	nature						

State of Maryland / Department of Health and Mental Hygiene () 0450 Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Year **Physician** MARIA NERINA McGUIRE March 11, 1998 0350 a.m. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY SACRED HEART HOSPITAL If Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) MARCH 2 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs. 73 ITALY Director 217 94 9744 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or ferms 23s or 28s-f show any injury or other traumatic event, the Medical Eventue must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND ALLEGANY CUMBERLAND 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S. 21532 14112 CEDARWOOD DRIVE, SW Funeral 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes XXNo Specify: Specify: g 3 √Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be ORESTE DELLA ROCCA EMMA CAROSELLI 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 14112 CEDARWOOD DRIVE, SW, CUMBERLAND, MD 21502 MICHELE McGUIRE / DAUGHTER 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Dete cemetery, cremetory or other plece) 1 Burial 2 □ Cremation 3 □ Removel from State MICHAEL CEMETERY 3/14/98 FROSTBURG, MD 21532 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee Quers 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Years Nephro Scleroe Diabetic The law requires that the death certificate be executed attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? s been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed director, page 2 s Valcular Discose alrove Knee amputation 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No al or Attending Physician: The satter death.
I Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Menny of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Deacribe how injury occurred Certification: 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dic completely filled in 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. Medical 29a, Certifier (Check only one) 29b. Signeture end title of cartifier 29d. Date signed (Month, Dey, Year) 29c. License number D14464 2

Tarn Lerrace Frostburg, ND 2153

Registrar **DHMH 16 Rev 6/95**

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State

Mander

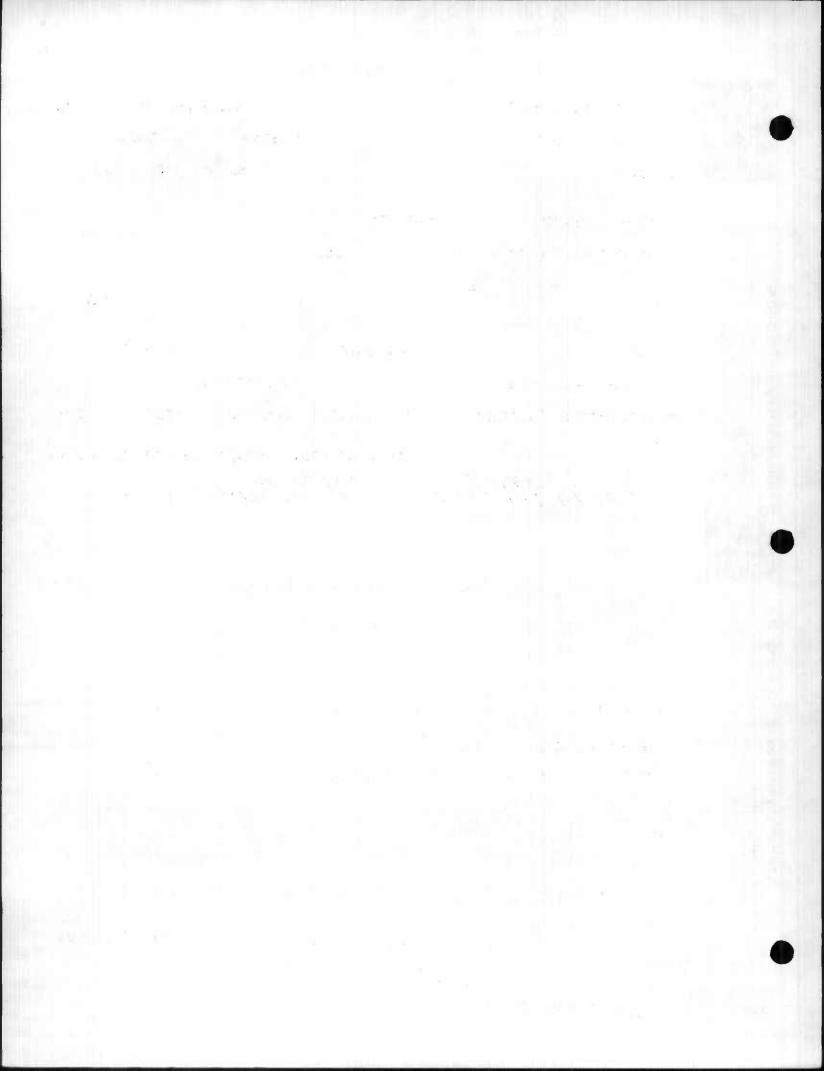
31. Date filed (Month, Day, Year)

MAR 1 6 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

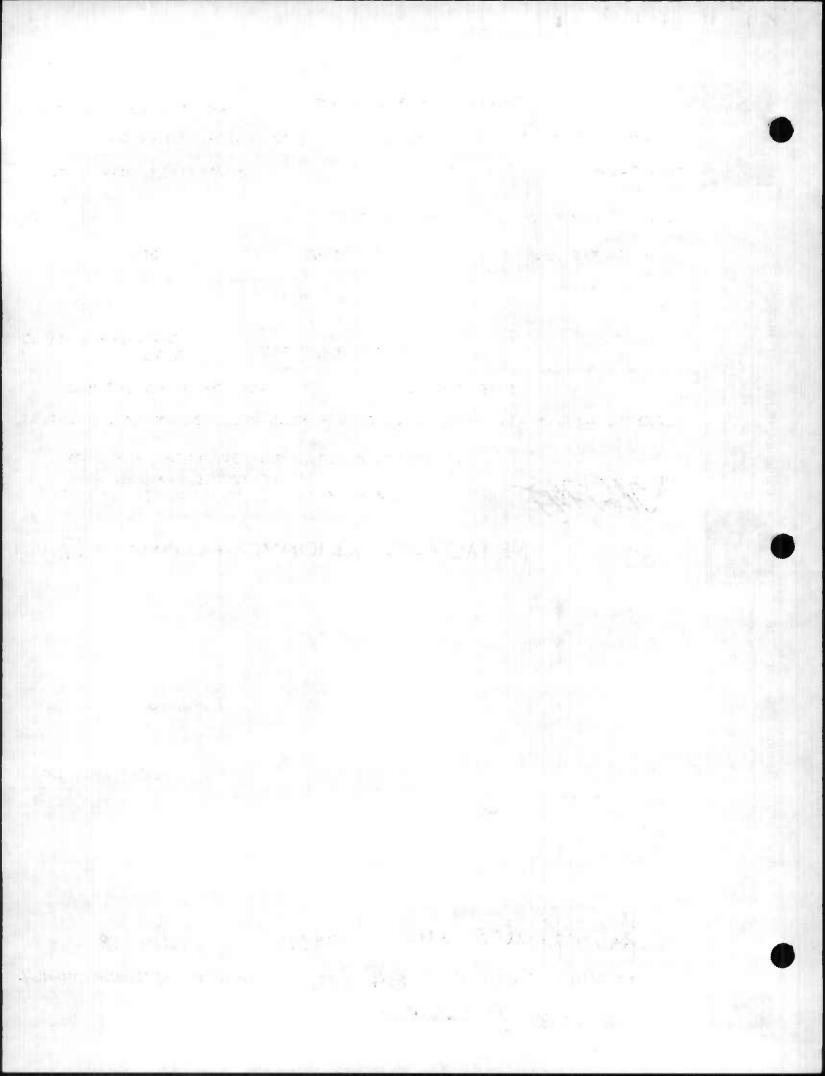
7 32. Registrar's Signature

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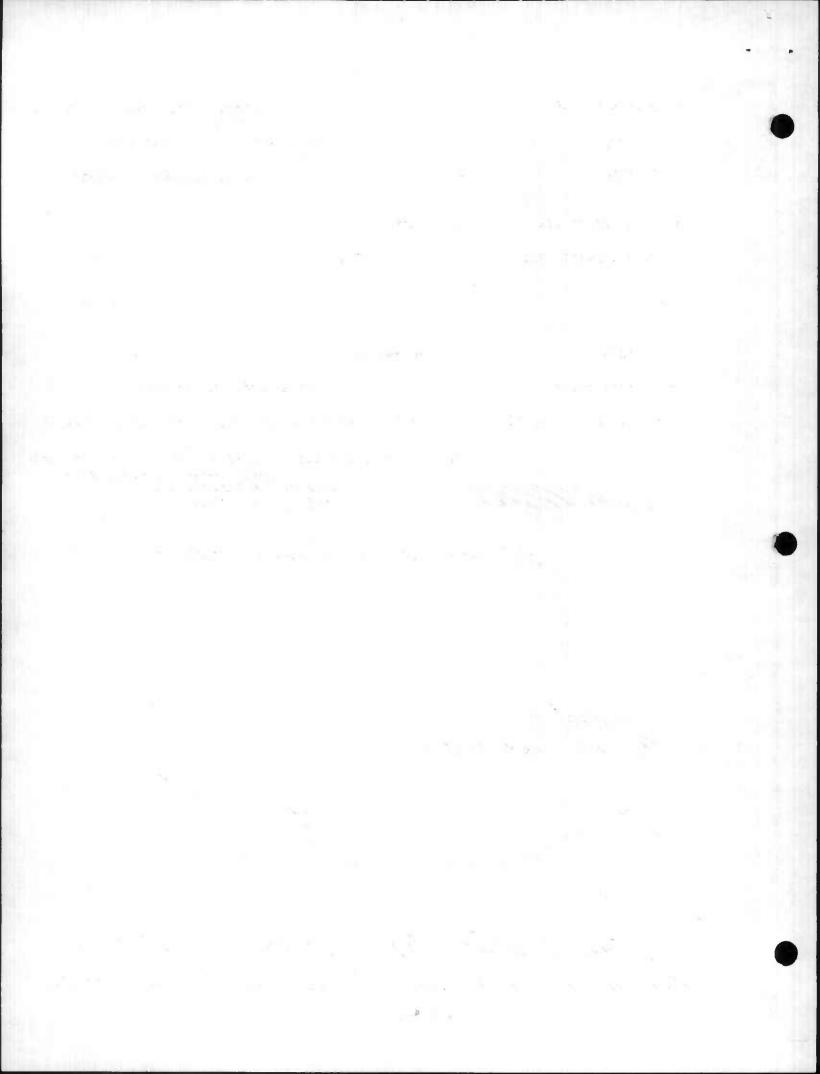
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			Ce	rtificate d	of Death		Reg. No.		0.0.
Physician /Medical	Decedent's Name (First, Middle, La		Y DELORE	s MENG	EL	2. Date of Month MARC	Dey	Year 998	3. Time of Death 5:50 AM
/Medical Examiner	4e Fecility Neme (If not institution, given CARROLL COUNT)		HOSPITA	L		wn, or Location of D MINSTER	eeth 4c. Count		
Funeral Director	214-32-4300	Sex 7. Ag	63 Yrs.		ear If Under	Min (Month	Birth Dey, Year) 1/1934	9. Birthp Cour MAR	place (State or Foreign http) YLAND
deeth with the Maryland ms 23s or 23s-1 show frough a contract neral Director	Usual Residence of Decedent 10a. State 10b. County MD • CARROI	L	10c. City, Town or L	ocation INSTER				1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the Mar to represent the representation	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of	What Cour	ntry?
23a or	1130 MARTIN DE	2.		21	157		US	Α.	
al', or he Exempte by Fu	11. Marital Stetus 1 Never Married 2 Married 3 V Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		Wes Decedent If Yes, specify (Cuben, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)		ce - Americ ock, White, fy: WH	
d within 72 piene. r than "nat re Magical	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or :	(Give	DO NOT use re	etired) ECRETA	RY	REPAIR	SION	dustry I & RADIO
d out	17. Father's Name (First, Middle, Last JOH	N LEROY					UDENCE	BARN	
d 2 should th and Mar 7 is merke traumatic	19a. Informant's Name/Relationship (VICKI L. LUTHE					er or Rurel Route Nu			MD.21157
of Heal of Heal f item 2 r other	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Placa of Disp	osition (Neme o	of place)	Date	20c. Location	- City or To	own, State
pemit. Pag Department Important: I any injury o page.	4 Donation 5 Other (Special Strates Lice		2	2. Name and A	ddress of Facilit	FLETCHET., WEST	R FUNER	AL H	IOME
death cartificate be executed a stranding physician and of for use as the burial-transit sician/Medical Examiner	23a. Pert1. Enter the disease, of shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. A. b		quence of):		MOSA		A	Infervel Between Onset and Death
as that the death or igned by the attand be detached for us by Physician	Pert II. Other significant conditions of	contributing to death b	ut not resulting In the	underlying caus	e given in Part i		Old tobacco use c		to the cause of death?
aw requiras as been sign 2 should be ipleted by						24a. V	Vas an autopsy enformed?	9/	Vere autopsy findings vallable prior to completion of cause if death?
The Late he page						1	□ Yes 2 □ No	1	Yes 20 No
s certificate director, pag	25. Was case referred to medical examiner?	Hospital:			26. Place Other:	of Death (Check of	nly one)		
After this funeral di	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, De			Injury at Work?		Residence 6 001		(y)
To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not to determined	289. Placa or in	ury - At home, farm, s c. (Specify)	treet, factory, of	fice	28f. Location City of	on (Street and Num Town, State)	nber or Rur	al Route Number,
he Hospit in 24 hour he Funera pletely fill edical ((Check only 2 Medical Exa	miner: On the basis o	of my knowledge, dea f examination and/or le	th occurred at the	ne time, date an my opinion, des	d place, and due to	the cause(s) and n	nanner as i	stated. to the cause(s)
To the H within 24 To the F complete	29b. Signature and title of certifier	and manner st	ated.	29c. Li	cense number		29d. Date sign		
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State Registrar	31. Date filed (Month, Dey, Year) MAR 2 0 1		ar's Signature Sixeleor Rand	Щ					



State of Maryland / Department of Health and Mental Hygiene

							C	Pertific	ate of	Death			Reg. No.	1 1		<u></u>
	Observator		1. Decedent's Name (First, Midd	le, Last)								2. Date of Do	eath	Vees	3. Tima c	f Death
	Physici /Medi		Anna Kate Mart	in								Mar.	Day 17, 19	998	2:40	P.M.
0	Exami		4a. Facility Name (If not institution	n, give street a	nd number	r)				4b. City, To	wn, or L	ocation of Dea		y of Death		
1			North Hampton	Nursing	Home	•			F	reder	ick		Frede	erick		
П	Funeral		5. Social Security Number	6. Sax 1 ☐ M 2[iga (In yrs. I		Mont	dar 1 Yaar hs Days	if Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)	9. Birth	olace (State	or Foreign
0 -	Director		213-74-7038	10141 21	-X1	92	Yrs	5.					, 1906	Mary		
	pue *		Usual Residence of Decedent 10a. State 10b. County			10c. City	. Town o	r Location					_	T.	IOd. Inside C	ity I Imite
	Aaryl f eho	ō	1 1 7 1													200 No
	the 1	Director	Maryland Frede	rick		Moun	t A1		Zip Code				10g. Citizen of	What Cou		
	with Sa or			1 1					•							
	leath ms 2	Funerai	13704 Unionvil		s Dacaden	t Ever in U.	S.		771 ecedent of F	lispanic Orl	lain? (Sc	ecify Yas or No	United 14. Ba	State ca - Americ		
0	r Her	Fur	1 ☐ Nevar Married 2 ☐ Mar	ried 1	ed Forcas	?		If Yes, s	pecify Cub	an, Mexicar	n, Puarto	Rican, etc.)		ck, White,		
21215-0020	72 hours effer death with the Marylend naturel; or Hems 23a or 28a-f show diest Example final be notified at	by	3 ☑ Widowed 4 ☐ Divorced		es, Give ir or Dates:			1 ☐ Ye	2	Specify:			Specia	y: Wh	ite	
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yla	Men Men arks	2	James Ezra Bak							Etta	Cor	dellia	Summers	3		
Maryland	2 sh end ls m		19a, Informant's Name/Ralations					_					er, City or Town			
	and leelth m 27		James D. Marti	n (Son)	1001 0				en Ch	urch		Myersvil			73
altimore,	ges if to It if the or of		20a. Mathod of Disposition 1X Burial 2 ☐ Cramation	3 □Removal	from State	9 06	emetery,		or other plac	,	į	Data	20c. Location			
Ë	tmen tant:		4 Donation 5 Other (5			Loc	ust		Ceme				Mount A	-	-	and
Bal	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinet must be notified at once.		21. Signature of Funeral Service	Licensee	11			22. Name	and Addra	ss of Facilit	y Bui	rier-Q	ueen Fur	ieral	Home	
_	402 9 0	_	- Cold	the	lle	re			Wi	nfiel	d, N	D 2178	4			
			Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death.													twaan
	Physician /Medical		Immediata Causa (Final		1 -		1	1	/ 1	,	1	1	(
	Examiner		diseasa or condition resulting in death)	des	len	pel	en	uch	ente	was	Her	Dea	Elist		~100	us
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	d d ansit	Examiner	Commented the time and distance	b		Due to /or		sequanca	nd).					+		
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P.O.	d by t	Phy	Pol. de	tie								10	Yes 2 No	3 Pro	bebly 4	Unknown
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ē												10	Yes 212No	10	☐ Yes 2☐	No
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	S 0	To	1 Yes 2 No 27. Manner of Death		1 L Inpati		ER/Outpa		DOA Oth	4 UPNU	irsing Ho		dence 6 □Oth		<i>y</i>)	
C	fund fund	ion	1 Natural 5 Pendin	ng	Data of Inju (Month, Da	ay Year)	28b. Tim Inju		28c. Injur Wor	yat k? Yes 2 □	No	280. Describe	how injury occur	red		
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Division of	or A effer Direct	Certification:	4 ☐ Homicida determ	lined 204.	building, e	c. (Spacify)	Street, lac	tory, office			City or To	wn, State)	Joi of Hare	i riouta regii	1001,
	spita nours neral		29a. Cartifier 1 Certifyli	g Physician: 1	o tha best	of my know	rtedga, da	aath occurr	ed at the tir	ne. data an	d placa.	and due to the	causa(s) and m	annar as s	tated.	
	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Madical one)	Examinar: On	the basis of mannar st	of axaminati	on and/o	r invastigat	ion, In my o	pinion, dea	th occur	red at tha tima,	date and placa,	and dua to	tha cause(s)
	To the To the Comp	×	29b. Signature and titta glornifie			7	11	7.	29c. Licans	e number			29d. Data signe	d (Month,	Day, Year)	
			Men	20	1	eg,	11	20	D	764	96		3/1	8/	Sf	
			30. Nama and address of person	who complated	causa of	death (Itam	23a) (Ty	pe, Print)	-	,		10	,	,		
			Flancis 1	2 /	ect	0-1	7/	2/1	100	Wig	11/	11/19	cherce	6,14	d 21.	201
	Sta		31. Date filed (Month, Day, Year)	1000		rar's Signat		1 .4				/				
	Registr	ar	MAR 1	1998	java	au ilumble	er Mar	dell								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend #8 WCHD 3/25tate of Maryland / Department of Health and Mental Hygiene 0 Amend HI WCHD 3/16/98 ead Certificate of Death Amend 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Rollen Rollon McKinney ,SR. March 10, 1998 /Medical 11:15 PM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico
3/08/26
9. Birthplace (State or Foreign
Fround AUD. FL. Salisbury Center; Genesis ElderCare Salisbury,
If Under 1 Year | If Under 24 Hrs. | 8.
Months | Days | Hours | Min. | 8. Md 8. Date of Birth 3/08/26 (Wordth, Day, Xear) MAR 10, 26 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2 ☐ F Yrs. Director 218-16-7500 Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maxical Examinar must be notified at WICOMICO SALISBURY MD. 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801 1000 WEST ROAD pemit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Marine 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Reca - American Indian, Bleck, White, etc. 1X) Yes 2 □ No USS If Yes, Give Year or Dates:1944 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorcad Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION WORKER LABORER 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman HERMON McKINNEY JULIA_WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERTRUDE McKINNEY ADDRESS SAME AS ABOVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 3-16 HURLOCK, MD. MD. VET. 21. Signature of Funeral Service Licansee 22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL llei 1213 JERSEY ROAD, SALISBURY, MD. 21801 23a. Pari1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one dause on each ling. **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medicai MONTE Examiner Examiner ettending physician and I for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? MyseaTersion Yes 2 No 3 Probably 4 Unknown by PRIOR STOROLSE 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1□ Yes 27 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Wing Home 5 Residence 6 Other (Specify) 10 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending P
 24 hours effer death.
 Funeral Director: After t After Natural 5 Pending Investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the within 2 29c. License number 29d. Dete signed (Month, Day, Year) an D39813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804 31. Date filed (Month, Day, Year) 32 Registrar's Signature Pardall MAR 1 6 1998 Registrar

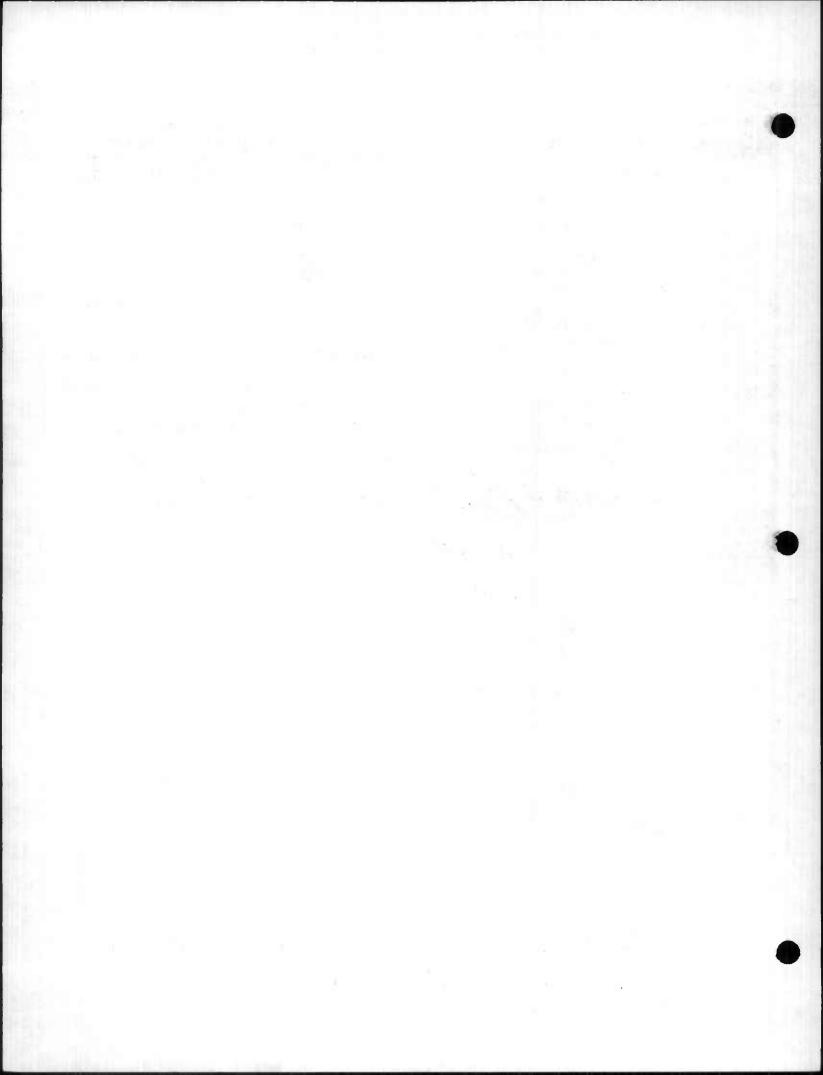
DHMH 16 Rev 6/95

Correction was made at LHD, a fax letter from Dr. Atkins 4/15/98 to change name reb 4/17/98 G-758

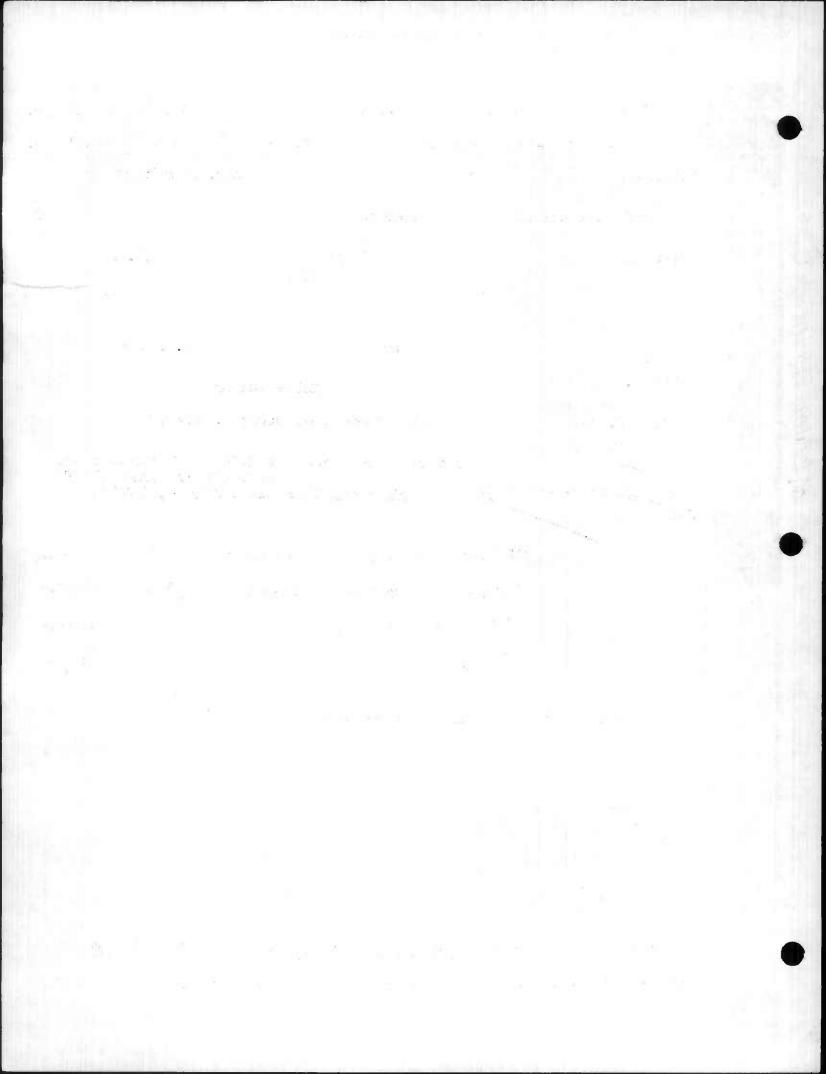
State of Maryland / Department of Health and Mental Hygiene

10454

							Ce	rtificate of	Death		Reg. No).			
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	Exami		4a. Facility Nama (If not institut	ion, giv	a street and nu	m <i>ber</i>)			4b. City, Town,	or Location of De		. County		2.31	1 .11
ſ.	-		5535 MOH	RRIS	RD.				PΤ	TTSVILLE	,	WIT	COMIC	0.	
Т	Funerai	Г	5. Social Security Number	6. S	ax	7. Aga (In yrs.	last birthday)	If Undar 1 Yaa	r if Under 24 H	rs. 8. Data of E				piace (State otry)	or Foreign
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	or 28	Director	10e. Street end Numbar					10f. Zip Coda			10g. Cit	tizen of V	Vhat Coun	itry?	
	th wi		5535 MOI	RRIS	RD.				21850			U.S.	. A .		
	- dea	Funeral	11. Marital Status		12. Was Deci	edant Ever in U	I,S. 13.	Was Decedant of If Yas, specify Cu	Hispanic Origin?	(Specify Yas or I	Vo-		- Amaric k, Whita,	an indian,	
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yıa		2	WILLIS			MORE	RIS		WI	LSIE			J	ONES	
o	and and		19a. fnformant's Name/Ralatio	nship (Type, Print)		19b. Maili	ng Addrass (Stree	et and Number or	Rural Routa Num	ber, City o	or Town,	Stata, Zip	Coda)	
	1 and 1 Health em 27		PAUL BRITTI	NGH	AM		3455	5 MT. I	HERMON R	D. PARS	ONSBU	JRG,	MD	21856	
ב	of Healt of Healt I Item 2 r other		20a. Mathod of Disposition 1 X Burial 2 Cramation		Damaust from			sition (Nama of matory or other pl		Data			City or To		
alilliore,	Peg nent int: h		4 Donation 5 Other				OWELLV	ILLE CEM	ETERY	3-17-98	POW	ELLV	ILLE	, MD	
Dall	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funaral Sarvio	e Licen	sea //	2	0/	Nama end Addi			05 E				
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	eath certificate be executed attending physician and for use as the bunal-transit	edical	resulting in death) Last	1		Dua to (o	r as a conseq	uence of):							
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DIVISION	Attending in death. Sector: After by the fune	Certification:	2 Accident invas	tigation				M 1E]Yas 2□No						
2	rect freed	틭		mined	28a. Piece	of Injury - At he	oma, farm, str	eet, fectory, office		28f. Location City or T	(Straat ar		er or Rura	l Routa Num	iber,
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Cartifiar 1 ☐ Certify (Check only one)	ing Phy at Exam	inar: On the be	best of my kno asis of axamina nar statad.	wledga, daath tion and/or inv	occurred at tha transfer occurred at the trans	ima, data and pla opinion, daath oc	ce, and dua to th curred at tha time	a causa(s) a, data and) and mar d place, a	nnar as st ind dua to	atad. tha causa(s	;)
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	/		MAUN	Y	On			1 1 3	dr cvs		3/	16/	9 8.		
	1		30. Nama and addrass of perso	n who c	complated ceus	e of death (Item	23a) (Type	Print)			1	1	, ,		
	9		Tankin L	. A	Made	om.	1.	prm	-						
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				State of Ma	aryıar				Health and I <i>Death</i>	Mentai Hy	Reg. No.	8 10	455
	ysiciar Medica	1	Decedent's Neme (First, Middle, Las Helen	Colleer	ì		Mecur	n		2. Dete of D Month Marc	Dey h 14, 19	Year 998	Time of Deeth 2:50pm.
	amine eral ctor		5. Sociel Security Number 6. Se	munity H	ospi e (In yrs.	tal last birthday Yrs.	/) If Unc	dar 1 Yaar ns Deys		1		e Geor	ge's Co. (State or Foreign
dand	w		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Ci	ty, Town or L	ocation						nside City Limits
death with the Maryland	be notified at	000	Maryland Anne Art	undel		Lo	thia	n				1	☐ Yes 2 📈
with th	Z 2		10e. Street end Number					Zip Coda			10g. Citizen of	,	
20 s after . or ite	Dumiper mus	2	294 Main Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 No. 1 Yes, Give		J,S. 13	Was Dec	20711 cedent of I pecify Cub	Hispenic Origin? (S an, Maxican, Puert	pecify Yes or No Rican, atc.)	o- 14. Rec Bte	S.A. De - American Ir ck, White, etc. V: White	ndien,
He / f / f / f / f / f / f / f / f / f /	ne Medical I	mbleted	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	Yaer or Dates: ucation de completed) College (1-4or 5	5+)	16a. Dece (Giv life. Cook	e kind of t DO NOT	suei Occuj work done use retire	pation during most of world)	king	16b. Kind of B		у
GWM He is the interpretation of the interpre	any injury or other traumatic event, if ones.	0	12 17. Father's Name (First, Middle, Last) Elzie O. Cook						18. Mother's Nen Esther I	Harmon			
ECUM timore, Mary Pages 1 and 2 shou ment of Health and Minent of Health and Minent. If New 27 1s mar	r traum		19e. Informent's Neme/Relationship (7 Esther J. Cook	ype, Print)					end Number or Ru ane, Mand		-		(0)
	e othe		20e. Method of Disposition 1 Buriai 2 Gremetion 3	Ramouei from State	20b. I	Piece of Disposematary, cri		-		Date	20c. Location		State
ALCUM Baltimore, Maryl pemit. Pages 1 and 2 shoul Department of Health and Me Important: if item 27 is mark	ny injury o		4 Donetion 5 Other (Specify,)	Lee		22. Name	end Addre	ess of Facilityee	Fuenra.	l Home, I		
M 892	4.00	١,	236. Part1. Enter the disease, or comp	_/					Ferry R				proximale prvei Between
Records, P.O. Box 68760, The law requires that the death certificate be executed that the death certificate be executed that has been signed by the attending physician and the property of the particular and the property of	ical bunal-transit uer leadical Examiner		Immediate Ceuse (Fine disaesa or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Undartying Ceuse (Diseese or injury that initiated events resulting in deeth) Last	cor	Due to (c		equence of	NOT OI): AVE	DIFE	LEST BASE	and	3	tyrs
Box 6 eath certific	for us												0
IS, P.O. as that the de	lached		Pert II. Other significant conditions co		ut not res	uiting in the	underlying		ven in Part I.		tobacco use co		cause of death?
Records, he law requires t a has been signe	should		·		-		_			perf	s an autopsy ormad?	avaitab comple of deeti	
Vital liclan: Th	Be Co		25. Wes case referred to medical						26. Plece of Dee		Yes 2 11 No	1 Ye	s 2 No
Phys of	tion: To		examiner? 1 Yes 2 DNo 27. Menner of Oeeth 1 DMaturel 5 Pending investigation	Hospital: 1 papatie 28a. Dete of Injur (Month, Des		28b. Time Injury		28c. Inju			idence 8 Oth		
Division fal or Attending ars after death.	lied in by the funeral Certification:		3 Sulcide 6 Could not be determined	28e. Plece of Injubuilding, etc	ury - At h	ome, ferm, s	treet, fact			28f. Location City or To	(Street end Numb wn, Stete)	per or Rural Ro	ite Number,
P Hosp 24 hou	pletely til		29a. Certifier (Check only one) 29a Certifier (Check only one) 1									enner es steted end due to tha	cause(s)
To the Within	Сощо		29b. Signeture end title of certifier	t			2	29c. Licens	se number		29d. Dete signe	d (Month, Day,	Yeer)
		-	Name and address of access	/~0 -		ENAN		D	16197		8-10	1-018	
			10. Name and address of person who or	2 ho -9	326	HA	m-	४०५	of Ro). Vo	HABM.	mp .	MOG.
Rec	State distrar	3	11. Date filed (Month, Day, Year)	32. Registre	r's Signe	ture Ran	dall						



Baltimore, Maryland 21215-0020

8-1738-02 .K.S		se Type or Pri	nt In Blac	k Inde	elible l	nk	. Assu	re A	II Coples	Are Leg	glble.	
RNOLD AUS	STIN NORTON Items: 23 part I,27,		laryland / [G-758 4/1	Depar 5/98 Certi	tment of	of F	lealth a Death	ind N	flental Hy	giene g	8	10456
	1. Decedent's Name (First, Middle								2. Date of De			3. Time of Death
Physician /Medical	Arnold	Austin	Norto	n					Month MARCH	28, 1	.998	1351 PM
Examiner	4e Facility Name (If not institution								ocation of Deat		nty of De	
	HARFORD MEMOR								GRACE		RFORD	
Funeral Director	5. Social Security Number 214–72–5543	6. Sex 7. A 1.25-M 2.□ F	ge (In yrs. last bin 34		If Under 1 Months [Year	If Under a	Min.	8. Date of Bir (Month, Da Feb. 1	th ly, Year) 0, 1964	(rthplace (State or Foreign country) cyland
and and	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loca	ition							10d. Inside City Limits
Maryl she	Maryland Harf	ord	Abo	erde	en							1 ☐ Yes 2 ☑ No
vith the Ma t or 28s-f s be notified	10e. Street and Number				101. Zip C	ode				10g. Citizen o	of What C	country?
3a o	431 Holly Drive					2	1001				US	Δ
ifter death v r items 23s rifter must	11. Marital Status	12. Wes Decedent		13. Wa	as Deceder	t of h	dispanic Orig	gin? (Sp	ecify Yes or No Rican, etc.))- 14. F		erican Indian,
by	3 ☐ Widowed 4 ☐ Divorced	ed 1 Tyes 200 If Yes, Give Year or Dates:			Yes 2X			, r denc	rioan, ec.,		cify: B.	
72 hc	15. Decedent (Specify only highes		16a.	Deceder (Give kir	nt's Usual (Dccup done	oation during most d)	of work	ding	16b. Kind of	Busines	s/Industry
ed within 72 ho ygiene. ner than "naturi it, the Peacal Completed	Elementary/Secondary (0-12)	T	College (1-4or 5+)				orker			Food	d Sei	rvice
d be file and Hyge ed others:	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											
marke marke	19a. Informant's Name/Relationsh	-		Mailing	Addrass (5	Straei			rel Route Numb			Zip Code)
treu				-								
A Head	Robert J. Norton, Sr. / Father 431 Holly Drive, Aberdeen, Maryland 2100 20a. Mathod of Disposition 1 XBurial 2 Cremation A Removal from State 20b. Place of Disposition (Name of cemalary, cramatory or other place) 20b. Place of Disposition (Name of cemalary, cramatory or other place) 20c. Location - City or To											
Page nert or ny or	1 XBurial 2 Cremation A Removal from State 4 Donation 5 Dother (Section 1) John Wesley Cemetery 4-3-98 Abingdon, Ma											
permit. Departir Imports any inju	John Wesley Cemetery 4-3-98 Abingdon, 21. Signature of Funeral Service Ucersee 22. Name and Address of Facility Howard K. McComas III Funeral Home,											P.A.
CONTRACTOR OF THE PARTY OF	23a, Parti. Enter the disease, or	complications that cook	to the dealer. Do r	13	17 Co	ke	sbury	Roa	d, Abin	gdon,	Mary	land 21009
Physician		one cause on each	line.	outer		,.	, c					Interval Between Onset end Deeth
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	NARCOTIC	INTOXICAT	TION								
ner d			Due to (or as e	conseque	ence ot):							
e executed an and riel-trensit	Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disaase or Injury	D	Due to (or as a	conseque	ence of):							
ng physician es the buriel	that initiated events rasulting in daath) Last	Due to (or es e o	conseque	ence of):								
eath certific attending p for use es	d											
d by the deteched	1 □ Yss 2 □ No										ts to the cause of death? Probably 4KUnknown	
signe dbe dbe									24a Was	an autoney	241	. Wara autopsy findings

3 Suicide

4 Homlcide

To the Hospital or Attending Physician: The lew requivithin 24 hours after death.

To the Funeral Director: After this certificate hes been completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed

Division of Vital Records, P.O. Box 68760,

performed?

available prior to completion of cause of daeth? Yes 2□ No 1 Yes 2□ No

25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Hospital: 1 ☐ Inpatient XXER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XIVes 2□ No 3□ DOA

28b. Time of Injury 12:05 A 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending invastigation 1 Natural 3/28/98 12:05 1 Yes 2 No Subject ingested drugs 2 Accident 6XX Could not be determined

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) motel

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 700 S. Philadelphia Blvd Aberdeen, Md. [Clays Motel

MARCH 29, 1998

29a. Cartifiar (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

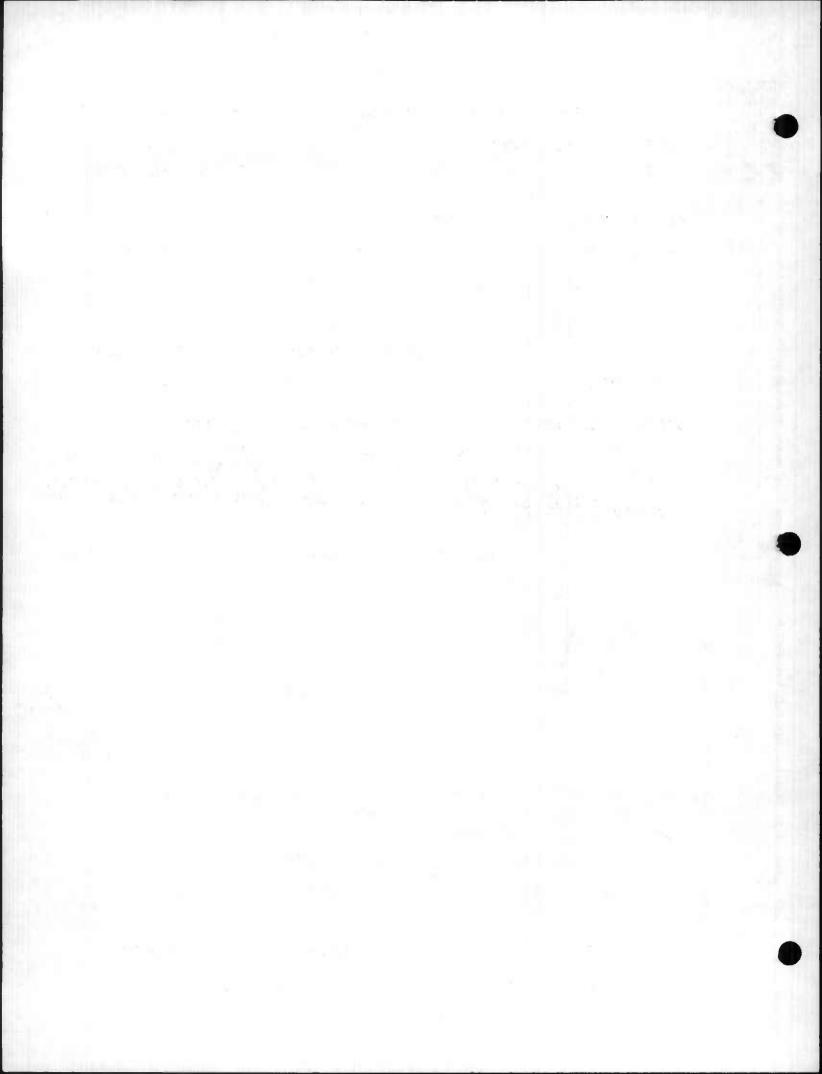
111 Penn Street, Baltimore, Maryland 21201

State Registrar

Strophen S 31. Date filed (Month, Day, Year) APR 0 2 1998

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month MARCH 21, 1998 ROWENA 09:35 am /Medical ELTZABETH NEWELL. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** PRINCE FREDERICK CALVARIANT CALVA CALVERT MEMORIAL HOSPITAL CALVERT If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funerai** Months Deys 1 M 2 TF **UNAVAILABLE** 33 Yrs. JAMACIA Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 ☐ Yes 2X No MARYLAND CALVERT LUSBY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 355 THE BITTER END 238 20657 JAMACTA deeth Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: itams 14. Race - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispenic OrlgIn? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner filed within 72 hours after 1 Never Merried 2 Married 5 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede com 16b. Kind of Business/Industry completed) al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) MENTALLY CHALLENGED NOT APPLICABLE Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Pages 1 end 2 should be fill ment of Health end Mental Hant: If itam 27 is marked oth lury or other traumatic even Be OWEN NEWELL LUCILLE MC DONALD 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LAURENCE SMITH/UNCLE 355 THE BITTER END LUSBY, MARYLAND Baltimore, 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State MARCH Department of Important: If any Injury or once. LEE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 23,1998 22. Name end Address of Fecility LEE FUNERAL HOME CALVERT, P.A. 21. Signature of Fineral Service Lices 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND of 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel bx-41 Canul disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest pue the buriai-tran Due to (or es e consequença of): Box 68760, ettending physician Physician/Medical Due to (or es e consequence of) the e Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the causa of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, p Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? peed this certificate has pege 2 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how Injury occurred After Division Attending 5 Pending investigation 1 BNatural 1 ☐ Yes 2 ☐ No s efter deeth deeth 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 To the Hospital within 24 hours e To the Funeral C 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted. Medical 29e. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 04/314 30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) Dr. Paul V. Pomilla, M.D., Prince Frederick, Maryland 20678 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State MAR 2 5 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daeth 3. Tima of Death Month Physician ANNA MARY OBRIEN MARCH 14, 1998 cation of Death 4c. County of Death 1850 P.M. /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sax Birthplaca (Steta or Foreign Country) **Funeral** 1□M 20XF Days Yrs. Director 68 MAY 6 1929 MARYLAND 218 24 8739 Usual Residence of Dacedan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 271s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example notiting any. 10a Stata 10b County 10c. City, Town or Location 10d Inside City Limits MARYLAND ALLEGANY PINTO 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 14216 WALTER DRIVE 21556 U.S. 14. Rece - American Indien Funeral 12. Was Dacedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No It Yas, Giva Yeer or Detes: Wes Dacedant of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marltel Status Bleck, Whita, atc. 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: WHITE Specify. by 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Eiemantary/Sacondary (0-12) Collega (1-4or 5+) OWN HOME 10 HOMEMAKER 18. Mothar's Nama (First, Middle, Meiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be GEORGE SHOEMAKE CORA WINEBRENNER 19a. Intorment's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) 14216 WALTER DRIVE, PINTO, MD 21556 CLARANCE OBRIEN / HUSBAND 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) FROSTBURG MEMORIAL PARK 3/18/98 | FROSTBURG, MD 21532 21. Signeture of Funeral Service Uce 22. Nama end Addrass of Facility SOWERS FUNERAL HOME, P.A. RUGE 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Pert1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one ceuse on each line. Approximate Intarval Batwean Onset end Deeth **Physician** End stage Chur Spetunting Polamory Disage /Medical Immediata Causa (Final disaasa or condition rasulting in daath) **Examiner** Examiner The lew requires that the death certificate be executed physician end s the buriel-trensit Sequantially list conditions, if any, laeding to Immadiata ceusa. Enter Undarlying Cause (Disaasa or injury that Initieled evants rasulting in daath) Last Dua to (or as a consaquance of): P.O. Box 68760. Physician/Medicai Dua to (or as a consaquanca ot) signed by the el d be deteched fo Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate hes lirector, page 2 s 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Osteolonsis Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica director. 25. Was casa rafarrad to madical axaminar? Be 26. Pleca of Death (Check only ona) Hospital: 15 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1 Yas 2 KNo Certification: To 28a. Data of Injury (Month, Dey Year) funeral 28c. Injury at Work? 27. Manner of Deeth 28b. Tima of 28d. Dascribe how injury occurred Natural 5 Panding 1 Yas 2 No 2 ☐ Accidant invastigation To the Hospital or Atterwithin 24 hours effer der To the Funeral Director completely filled in by the 3 ☐ Suicide 6 Could not be determined 28t. Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, tarm, street, factory, offica building, atc. (Specify) 4 Homicide edical † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steled.

2 D Medicat Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifia: 29c. Licansa number 29d. Data signad (Month. Dev. Year) 29b. Signature end titla of certifier V2-1246 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

State

Registrar

31. Data tiled (Month, Day, Yaar) MAR 1 8

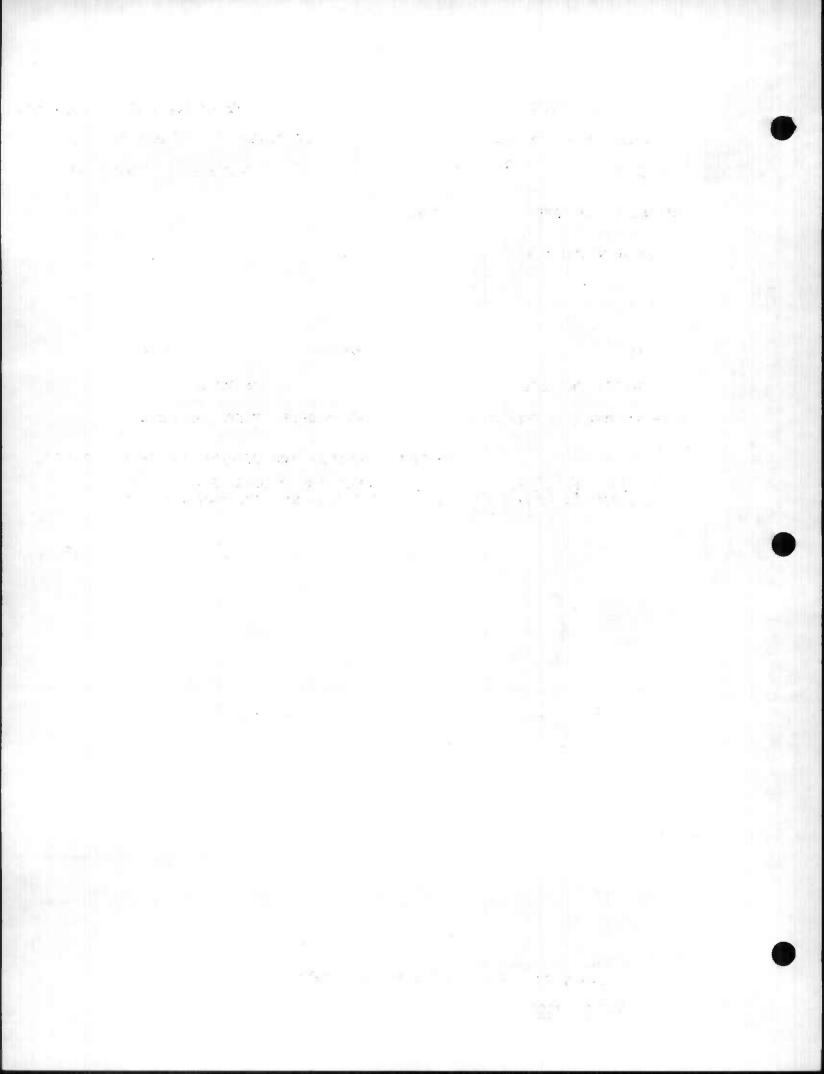
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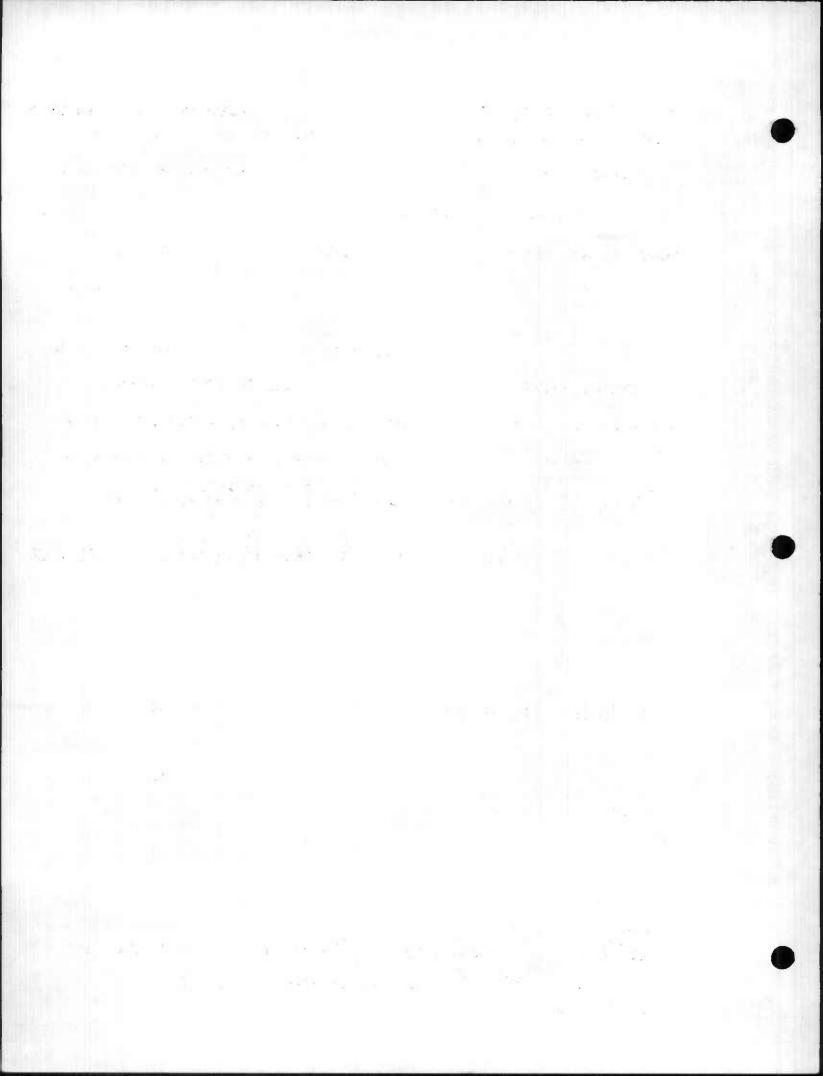
FROSTBURG, MD. 21532



State of Maryland / Department of Health and Mental Hygiene 8 1 1 4 5 9

							Cer	tificate of	Death		Reg. No.	1 1,7			
	Di Lista		. Decedent's Neme (First,	Middle, Last)						2. Dete of Da Month	ath Dey	Year 3	3. Time of Death		
	Physician /Medical	Ļ	HARVEY ELLI a Fecility Neme (If not inst	S OAT	ES, SR.	r)			4b. City, Town, o	MARCH Location of Deat	15 1998	0	8:00 AM		
7	Examiner		SACRED HEA			,			CUMBER	LAND	ALI	EGANY			
	Funeral Director		. Sociel Security Numbar 234–62–3808 Jsuei Residence of Decede		M 2□ F	nge (In yrs. la 59	ast birthday) Yrs.	If Undar 1 Yaa Months Dey			in 1938	9. Birthplece Country VEST VI	(Stata or Foreign		
	Maryland -f show filed at	1	Oa. State 10b. Co		L		, Town or Loc EYSER	ation					Inside City Limits		
	ifiar deeth with the Mai r thems 23a or 28a-f s nine must be notified	1	0e. Street end Number	ox 18	4-A1			10f. Zip Code 2672			10g. Citizan of N				
020	by hy	2	1. Marital Status 1 ☐ Navar Merried 2 3 ☐ Widowed 4 ☐ Div	Married	2. Wes Deceder Armed Forces 1 ☐ Yes 2 5 If Yas, Giva Year or Detes	s? ₹No	If	/es Decedent of Yes, specity Cu □ Yas 2 🟋N	Hispenic Origin? (ban, Maxican, Pue Specify:	Specify Yas or No rto Rican, etc.)		e - American i ck, White, etc. WHI			
21215-0020	c ' 0 -		15. Dec (Specify only I Elementery/Secondary (0	-		r 5+)	(Give k life. D	ent's Usuel Occ ind of work don O NOT use retii	a during most of w red)	orking	16b. Kind of B	usiness/Indust			
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lary	2 should and Men is marke		19a. informent's Neme/Rele	etionship (Typ	pe, Print)		19b. Meiling	Address (Stre	et end Number or I	Rural Route Numb	er, City or Town,	State, Zip Co	de)		
	1 and 2 Health em 27 I		ORPHA OATE	s / W	IFE	001 70			30X 184-				726		
Jore	60	2	0e. Method of Disposition 1 ☑ Burial 2 ☐ Crama		emovel from Stat	e C6	emetery, crem	ition (Neme of etory or other p		Dete	20c. Location				
altimore,						FOF				3/18/98	FORT	ASHBI	, WV		
Ba	permit. Departimontumontumontumontumontumontumontumontu	4 Donetton 5 Other (Specify) FORT ASHBY CEMETERY 3/18/98 FORT AS 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, INC.													
		+	23a. Part1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between												
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1	/Medical Examiner	1	Immediate Ceuse (Finel disaase or condition resulting in deeth)	0	Car		O MO		the	Prost	ate	1	Omo.		
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	death cartificate be executed a attanding physician and of or use as the burist-transit stellar/Medical Examiner		Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying			Due to (or	r es e consequ	ience of):							
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687	ng physicie as the bu		thet initieted events rasulting in daeth) Lest			Due to (or	es e consequ	enca of):				1			
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	the atte	F	ert II. Other significant co	nditions cont	ributing to deeth	but not resu	ulting in the un	derlying cause	given in Pert I.	23b. Dld	tobacco usa co	ntribute to th	e cause of death		
s, P.0	requires that the death ca seen signed by the attend hould be deteched for us,		Diabet	es 1	Melli	43				1 🗆	Yes 2 KNo	3 Probab	ly 4□Unknow		
of Vital Records	¥ 20 C										en eutopsy ormed?	aveila	autopsy findings ble prior to letion of cause hth?		
- B	The law									1 🗆	Yes 2 No	1 🗆 Y	es 2 No		
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	tending I laath. tor: After the funal	1	Naturel 5 P	ending evestigation	(Month, L	Dey Year)	Injury	28c. in W	ork? ☐ Yes 2 ☐ No	200. Dascribe	riow injury occur	100			
Division	or At offer of or by		2 Accident " 3 Suicida 6 C 4 Hornloide	28e. Pieca of I building,	me, ferm, stre	et, fectory, offic	9		(Street end Numi wn, Stete)	ber or Rural R	oute Number,				
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	To the comp		29b. Signature and title of o	ertifier /	\mathcal{O} -	. ()	34		nse number		29d. Dete signe	d (Month, Day	r, Year)		
	4		taul-	1. In	vergo	00/1	カカ	D	23774		MARCH ,	16 19	98		
	This	3	30. Name and address of page 2/2	erson who con	no etuale dause of	deeth (Item	23e) (Type, F	-land	md	2150	2				

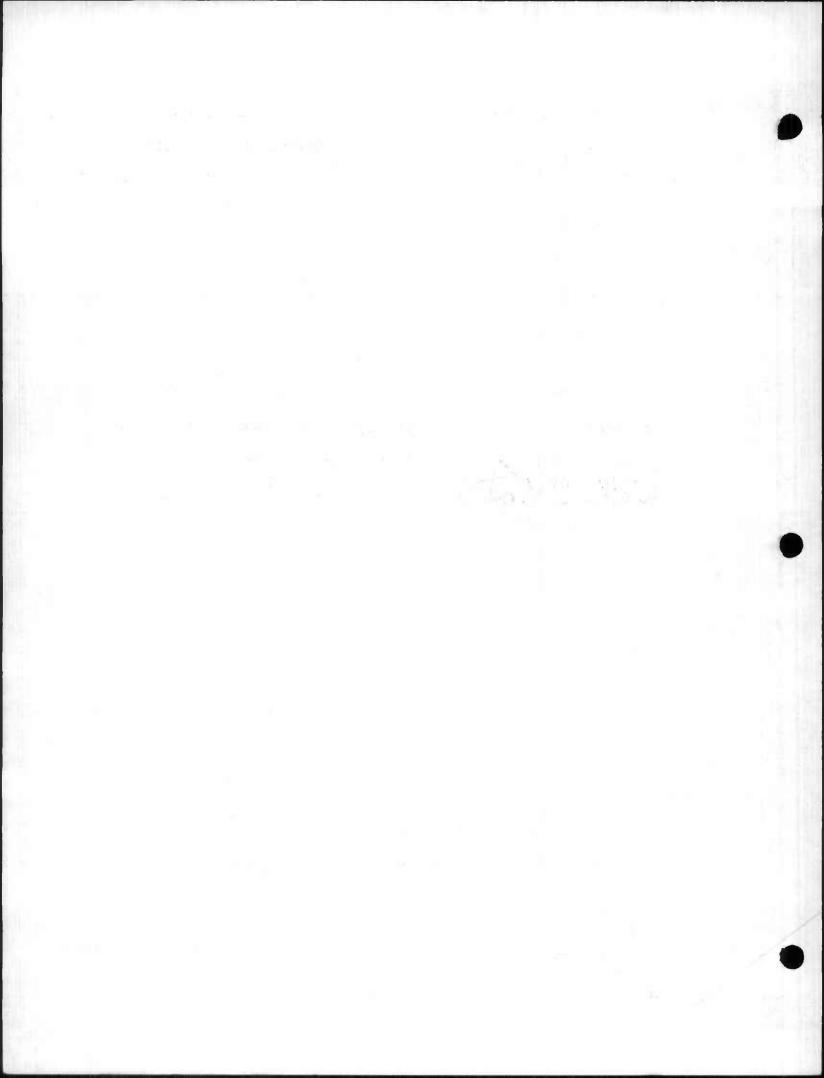
State Registrar 31. Dete filed (Month, Dey, Yeer) 82. Registrar's Signature MAR 1 7 1998



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					Otate of Ivi	ai yicai i			of Death	na mentai h	Reg. No.	8	0461	0
	Physici			e (First, Middle, Last, atherine E						2. Dete of Month	Day	Year	3. Time of De 4:30 A	
	/Medi Examir			If not institution, give					4b. City, Tow	n, or Location of De		of Death	4.30 A	TA1
,/	LAGIIII	161		ew Hope					Cumber	rland	Alle	tanu		
	Funeral		5. Social Security N		7. Ag	e (In yrs. la		If Under 1 Y	ear If Under 24	Hrs. 8. Date of I			place (Stete or F	Foreign
	Director		212-10-01 Usual Residence o	13]M 2 X]F	90	Yrs.	Months De	eys Hours		Day, Year) 1, 1908			
	the Maryland 28a-f show notified at	-	10a. Stete	10b. County			Town or Loca			-		1	Od. Inside City	
	M Page	cto	PA	Bedford		Cl∈	earville	е					1 🗆 Yes 2	XINO
	3a or 2	I Dire	Rt. # 3,	Box 273				10f. Zip Coo	535		10g. Citizen of t	Whet Cour	ntry?	
020	n 72 hours after death with the Maryland "naturel", or items 23s or 28s-f show edical Examiner must be notified at	by Funeral Director	11. Maritel Stetus 1 Never Marr	led 2 Married	12. Was Decedent Armed Forces? 1 Yes 25 h If Yes, Give Year or Dates:	Ever In U,S			of Hispanic Origi Cuben, Mexican, No Specify:	n? (Specify Yes or Puerto Rican, etc.)		ce - Americ ck, White, y: Whit		
21215-0020	pemit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mentel Lygiene. Important: If Item 27 is marked other than "nature any injury or other traumatic event, the Medical once.	Completed	Elementary/Seco	15. Decedent's Edu cify only highest grade endery (0-12)	cation e completed) College (1-4or 5	+)			cupation one during most of tired)	of working	16b. Kind of B		dustry	
D 2	Hygie ther nt.		17 Father's Name	(First, Middle, Last)			H	omemak		s Name (First, Midd	Own I			
Maryland	Wentel Wentel I	To Be	10-10-10	W. Harper						ttie C. (
a	sho and l me	ľ	19a. Informant's No	ame/Reletionship (Ty	pe, Print)		19b. Meiling	Address (St.	reet end Number	or Rural Route Nur	nber, City or Town,	State, Zip	Code)	
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Baltimore,	ages 1 nt of He I: If item / or oth			Cremation 3 💷	emoval from State	Ce	ace of Disposit metery, crema sperity	tory or other	place)	3/24	20c. Location -			
altir	permit. P Departme Important any injury		21. Signature of Ru	5 Other (Special)	VI					Kight Fu	,		I.A.	
<u> </u>	88 2 2 8		▶ WU	Mil	NAT	ע				St., Cum		MD21		
	Physician /Medical Examiner	er	shock, or hee Immediate Cause disease or condition resulting in deeth)	he disease, or compli rt failure. List only or Final n	Covo	nhn	- /	ery	disea		arrost,		Approximate Interval Betwee Onset and Dec	en ath
0,	ficete be executed g physicien end as the burial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate orlying). ————	Due to (or	es e conseque	ence of):				1		
Box 68760,		n/Medical	Ceuse (Diseese or thet initiated events resulting in death)			Due to (or	as a conseque	nce of):						
m	death cert e ettending ed for use	icia	Part II Other signif	Icant conditions con	tributing to dooth by	4	Miner In the const		alian in Bast I	22h D	d tahana ma	menthere e	n the equipe of	de ette 9
P.0	es that the de igned by the be detached	/ Physician/M	Part II. Other signif	can conducts co	imouting to death of	n not resu	ning in the uno	enying caus	given in Part i.		d tobacco use co			nknown
Records,	aw requir	Completed by					<u> </u>			24a. W	es an autopsy rformed?	av	ere autopsy find ailable prior to impletion of cau death?	
2	0 E B	0								10	Yes 20 No	11	Yes 2 No	.0
Vital	ucian: Th certificata rector, pa	Be	25. Was case refer	red to medical					26. Place o	of Death (Check on	y one)			
>	5 00	To	examiner? 1 ☐ Yes 2 ☐	No F	lospital:	nt 2 🗆 E	R/Outpatient	3□ DOA	Other: 4 Nurs	Ing Home 5 Re	sidence 6 Oth	ner (Spech	(v)	
ou of	ding Phys h. After this funaral di		27. Manner of Deat 1 Natural	5 Pending	28a. Date of Injur (Month, De)	У	28b. Time of Injury	28c.	njury at Work? 1 □ Yes 2 □ N	28d. Describ	e how injury occur		,,	
Division	Ar Attendent frector: n by the	Certification:	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								(Street and Numl Town, State)	ber or Run	al Route Numbe	97,
	To the Hospital of within 24 hours at To the Funerel D completely filled it	edical (29a. Certifier (Check only one)	1 Certifying Phys 2 Medical Examin	ician: To the best of her: On the basis of and manner sta	examinati	riedge, death o on and/or inves	ccurred at th	e time, date and ny opinion, death	place, and due to the cocurred at the time	ne cause(s) and m e, date and place,	anner as s and due t	tated. the cause(s)	
	o the	M	N.	title of certifier				29c. Lic	ense number		29d. Dete signe	d (Month.	Day, Year)	
	5		1 Japan) 33290 March 23,											
	That			ess of person who co				int)						-
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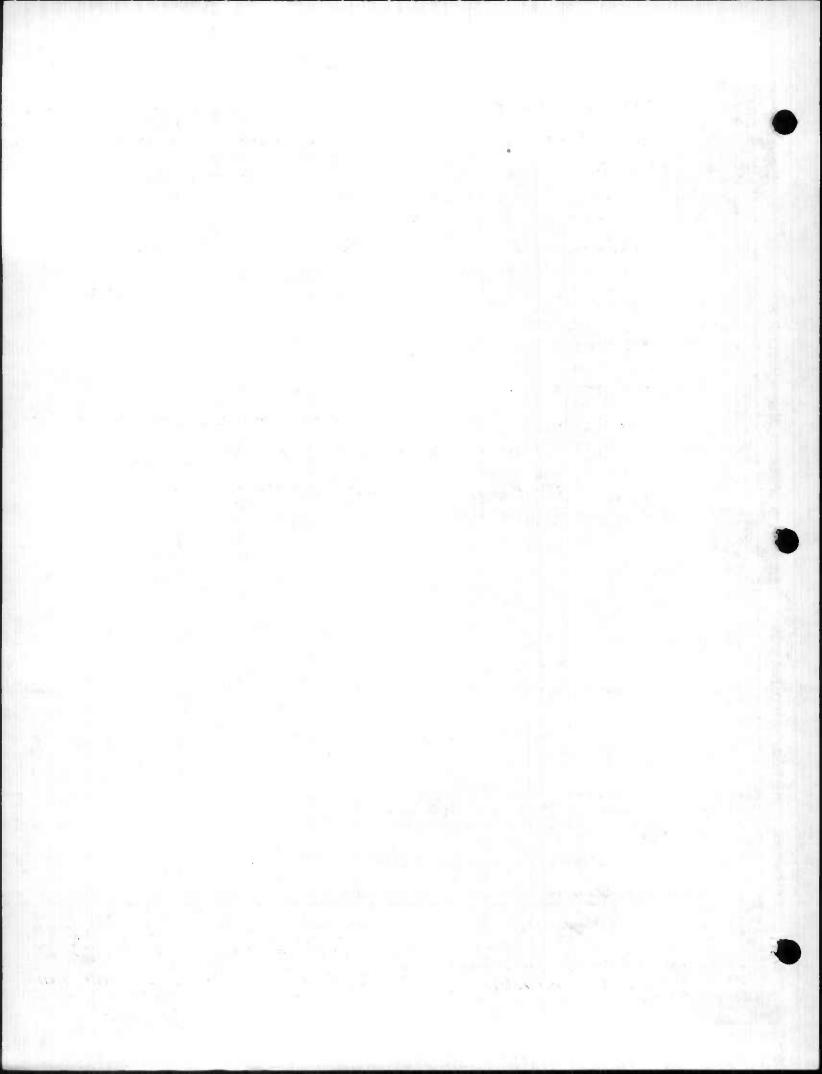
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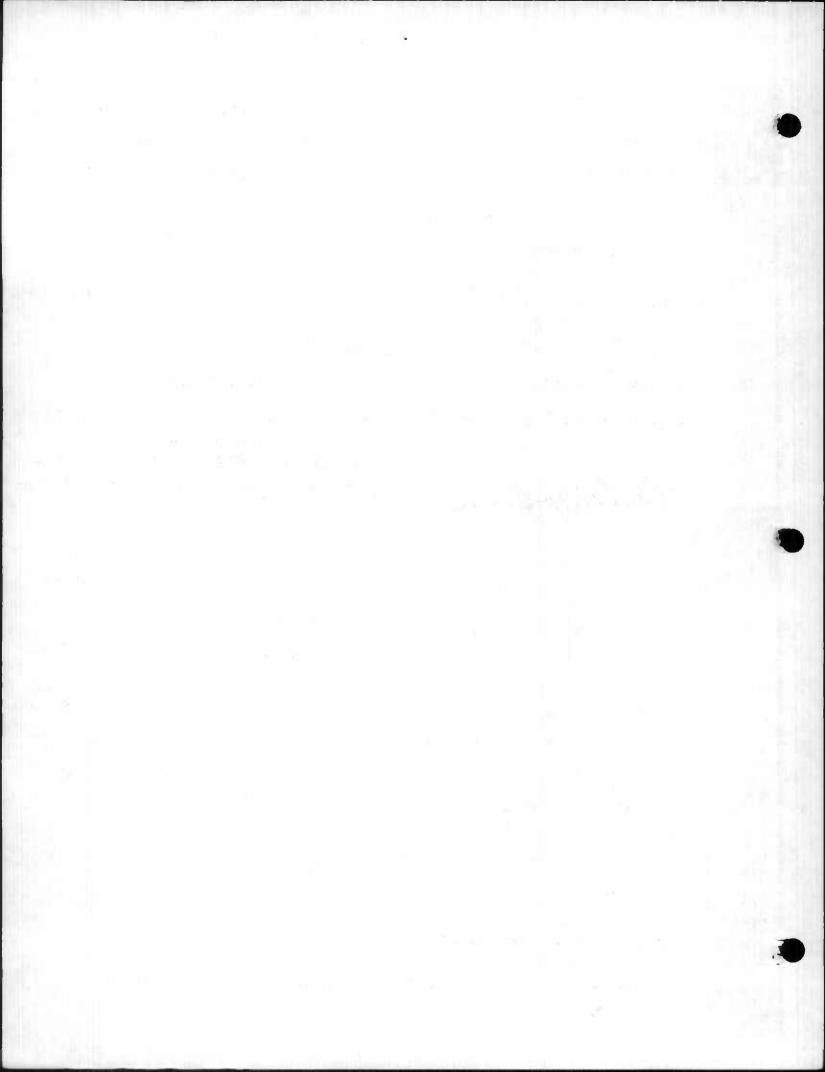
hysicia /Medica xamine						Cer	tificate o	t Death		Reg. No.		
/Medica	n	1. Decedent's Neme (First, Mic							2. Dete of De Month	eth Dey	3. T Yeer	ime of Deeth
		Esther Rebe	cca Po	well							11.	19 p.m.
	_	4e. Fecility Neme (If not institu			r)				March Location of Deat			
		Sacred Heart		tal				Cumber1		Alle	gany	
ineral ector		5. Sociel Security Number 217–05–9870	6. Sex 1 ☐ M	2⊠F 7. /	Age (In yrs. 85	lest birthday) Yrs.	If Under 1 Yes Months Dey			y, Year)	9. Birthplece (S Country)	Stete or Foreig 1D
	-	Usuel Residence of Decedent 10e. Stete 10b. Cour	No. o		100 0	y. Town or Lo						
S T I	١		*									ide City Limits
CHILL	Sct	MD Alleg	any		LC	naconi						Yes A No
Modical Examiner must be notified at	Funeral Director	10e. Street end Number 21211 Crystal					10f. Zip Code 21539			10g. Citizen of USA		
EXECUTATION	ρ	11. Maritel Stetus 1 □ Never Merried 2 □ M 3 ☒ Widowed 4 □ Divorce		Was Deceder Armed Force 1 ☐ Yes 2 £ If Yes, Give Year or Detes		,S. 13. V	Vas Decedent of Yes, specify Co	f Hispanic Origin? (uben, Mexicen, Pue lo Specify:	Specify Yes or No rto Ricen, etc.)	- 14. Rec Ble Specif	ce - American Ind ck, White, etc. y: White	ien,
lical lical	Completed	15. Deced (Specify only high	ent's Education	on muleted)		16e. Deced	ent's Usuel Occ	upetion	arkina	16b. Kind of B	usiness/Industry	
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2	Ö	9		0		Homem	aker			Home		
	Be	17. Fether's Neme (First, Middle	e, Last)					18. Mother's Ne	eme (First, Middle,	Maiden Sumer	ne)	
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traumatic		19a. Informent's Neme/Reletio		Print)				et end Number or F				
other tr		Billy Powell S	Sr.	5	Son	15901	Lower (Georges Co	reek RD,	Lonaco	ning, MD	21539
		20e. Method of Disposition 1 ☒ Burial 2 ☐ Cremetio 4 ☐ Donetion 5 ☐ Other		ovel from Stet	e Fro	Plece of Dispos emetery, crem stburg	sition (Name of netary or other p Memoria	al Park	March 22 1998	20c. Location	City or Town, St	ate
any injury or		21. Signeture of Funerel Service	ma	Kens	ii	F-4	Neme end Add	McKonnzi	Fimera	Home I	ο Δ	
		23e. Pert 1 Enter the diseese, shock, or heart feilure. L	or complicati	one that cous	ed the deet	h Do not ente	E. Mair	Street,	Lonacon	ing, MD	21539	xlmete
ing physician end as the burial-transit Medical Examiner	legical Examiner	resulting In deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Intileted events resulting In deeth) Lest	{	1	Due to (o	r as a consequ	ISON Jence of):	3 7	·81	TSP.	19	93
			d_								_	
of bed to	3	Pert II. Other significant condi	tions contribu	uting to deeth	but not res	ulting In the un	deriying ceuse (given in Pert I.	23b. Did	lobacco use co	ntribute to the co	uss of death
be detached for us.								-	10	Yas 2 No	3 Probably	4 🗆 Unknow
Completed										en eutopsy med?	24b. Were eute eveileble completio	
96 2											of death?	
Com									10	res 20 No	1 ☐ Yes	2□ No
director,		 Wes case referred to medic examiner? \ / 		** *					eth (Check only o	ne)		
al dire	2	1 ☐ Yes 2 No	Hosp	1 L Inpat		ER/Outpetient	3□ DOA	Other: 4 Nursing I	Home 5□ Resid	dence 8 □Oth	er (Specify)	
ed in by the funera	anon	E LI Modidoni	tigation	8e. Dete of In (Month, D	ury ey Year)	28b. Time of Injury	28c. Inj W M 1[ury et ork? □ Yes 2 □ No	28d. Describe i	now injury occur	red	
in by		3 Sulcide 6 Couldetel	mined 2	8e. Plece of It building, e	njury - At ho tc. <i>(Specif</i>)	ome, ferm, stre	et, factory, office	9	28f. Location (S City or Tox		per or Rural Route	Number,
24 hours after death Funeral Director: Hely filled in by the		29a. Certifier 1 Certify (Check only one) 1 Madica	Examinar:	On the basis	of exeminet	wledge, death ion end/or Inve	occurred et the estigetion, in my	time, dete end plece opinion, deeth occ	e, end due to the urred at the time,	ceuse(s) end ma dete and plece,	anner es steted. end due to the ce	use(s)
pletely filled	K I	end menner steled.								29d. Dete signe	d (Month Day Y	
completely filled		29b. Signature and title of certifier 29c. License							2001 D 410 BIS 10	a fundamin politic	987	
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pletely fill		29b. Signature and title of certif	1//	Mu,	2)		\mathcal{D}	252				1.0

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		State of Maryland / Department of Health and M Certificate of Death	, 0	eg. No. 9	3 104	62
Physic /Medi		Decedent's Name (First, Middle, Last) GARNET MCCOMIS PLUMB	2. Date of Dear Month March		3. Time of 8 8 : 3 4 8	
Exami		4a. Fecility Name (If not institution, give street and number) The Memorial Hospital at Easton Easton	ocation of Death	4c. County of Talbo	Death t	2 • MI •
Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Mont	8. Date of Birth (Month, Day July	^{Year)} 1917	Birthplece (State of Country) Onio	r Foreign
h the Maryland r 28a-f show	tor	10a. State 10b. County 10c. City, Town or Location Md. Queen Anne's Queenstown			10d. Inside Ci 1 ☐ Yes	
h with the	Funeral Director	10e. Street and Number 101 Rutledge Road 21658	1	0g. Citizen of Wha	-	
15-0020 72 hours after death with the Maryland "natural", or Nems 23s or 28s-f show edical Examiner must be nutified as	þ	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 2 □ Married 1 □ Yes 2 □ YOV 1 □ Yes Armed Forces? 1 □ Yes 3 □ YOV 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces? 1 □ Yes Armed Forces?	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
21215- 21215- I within 72 iene. ' then "nat	Completed	15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	sing	16b. Kind of Busin	ness/Industry	
aryland 2 should be filled nd Mental Hygis marked other umatic event, is	To Be C	17. Father's Name (First, Middle, Last) Millard McComis 18. Mother's Name Rub	e (First, Middle, I y (Unk			
re, Mar re, Mar stand 2 sh Heelth and tem 27 is m		19a. Informant's Neme/Relationship (Type, Print) Barbara A. Fields (Daughter) 19b. Malling Address (Street and Number or Rur. 10b. Malling Address (Street and Number or Rur. 10b. Malling Address (Street and Number or Rur. 10b. Malling Address (Street and Number or Rur. 10b. Malling Address (Street and Number or Rur. 10c. Place of Disposition (Neme of cemetery, cremetory or other place) Mar	Queen		Md. 216	58
Baltimore, permit. Peges 1 a Department of Hee important: If Nem any Injury or othe		4 Donation 5 Dother (Specify) Chesapeak Cremation Ce 21. Signature of Funeral Service Licenson 22. Name and Address of Facility Fellows, Helfent 106 Shamrock Ro 23a. Part. Enter the Greate, or compactions that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one masse on each line.	Stevens Newnam ster, M	ville, Funeral	HO:	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			Doy S	ween Deeth
uted d ansit	Examiner	Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Due to (or as a consequence of):			wee	KS
68760, flicete be executed physician and as the buriel-transit	edical	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			year.	
IS, P.O. Box 6 es that the death certificate by the ettending be deteched for use as	Physician/M	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contri	bute to the cause of	of death'
ls, P.O. es that the igned by the be deteche	by	veurogenic Bladden	1 🗆 Y	es 2□ No 3	Probably 48	Unknow
ecords law requires as been sign	Completed	revrogenic Bladden Cauda equina Syndrome Atrial Fibrillation	24a. Was a		24b. Were autopsy fi avelleble prior to completion of c of death?	0
of Vital Rec nysician: The law his certificate has be i director, page 2 s	Be Con	25. Was case referred to medical examiner? 26. Place of Death	1 ☐ Ye	,	1 ☐ Yes 2	No
On C dlng Pł h. After tł funera	Certification: To	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation 1 Subjects 6 Could not be	ence 6 Other (
DIVISI The Hospital or Attent hin 24 hours after deat the Funeral Director: npietely filled in by the		4 Homlcide determined 200. Flace of injury - Xt nome, ferm, street, rectory, office building, etc. (Specify) 29a. Certifier Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place.	City or Town	n, State)	or Rural Route Num	
To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and little of cartifier 29b. Signature and little of cartifier 29c. License number	red et the time, di	ate and place, and 9d. Date signed (1)	due to the ceuse(s Month, Day, Year))
· ·		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael F. Loos MD 210 S. Washington Ct. F.	30 c t	M2 24	601	
Sta	ate	Michael E. Lees, MD 219 S. Washington St., E 31. Date filed (Month, Day, Year) MAD 1 9 1998	aston,	MQ. 21	001	

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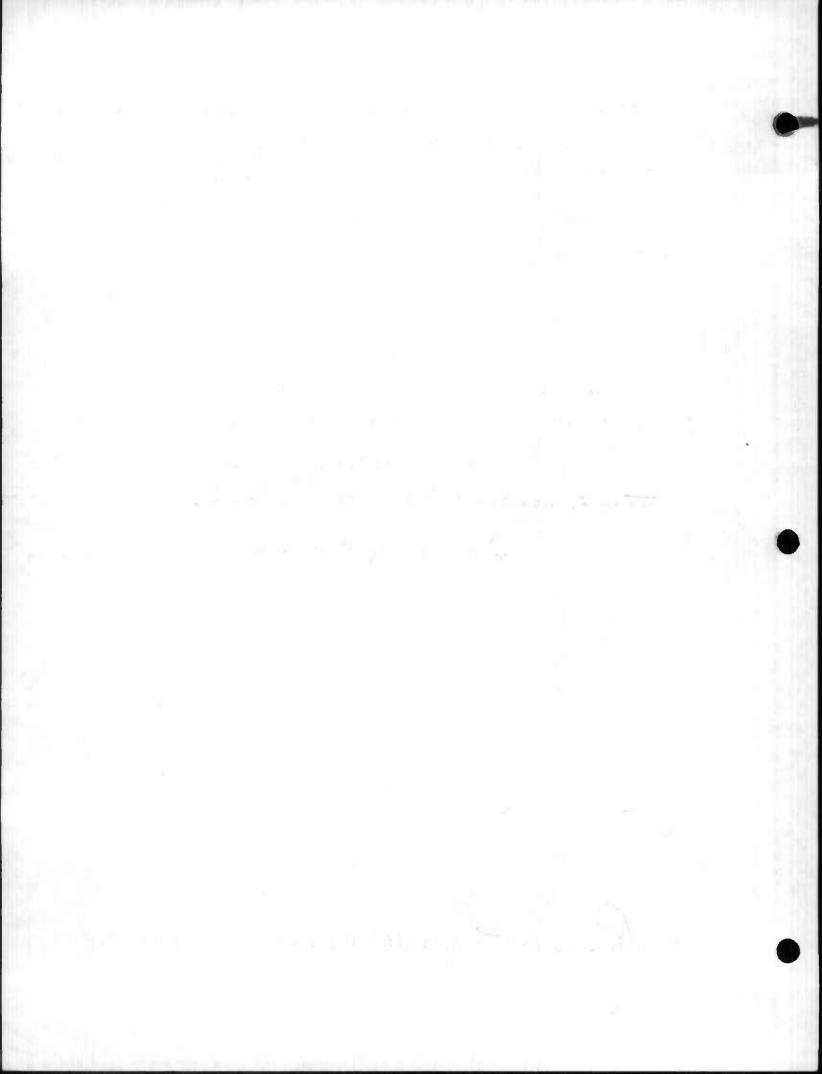


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. loade Type of Time III Black Illacible Illic	Adda C All Copies Ale Legible

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** Ronald 21, 1998 /Medical Α. PROTENIC March 8:11 AM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner The Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Birthplace (State or Foreign Country) Days 1⊠M 2□ F Months Hours Director 50-48-4379 Texas Sept.13,1952 Usual Residence of Decedent filed within 72 hours aftar death with the Maryland 10a. State 10c. City, Town or Location itam 27 is markad other than "natural", or items 23a or 28a-f show other traumatic event, tre Medical Expenses must be notified all 10d. Inside City Limits 1 ☐ Yes 🌪 ☐ No Director Queen Anne's Queenstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 Kehm Road Funeral 21658 U.S.A.
14. Raca - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Yes 2 No 1 ☐ Yes XIXNo Specify: Specify: White Completed by 3 Widowed 4 Divorcad Year or Dates: 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed with Department of Haalth and Mantal Hygiens Important: if item 27 is marked other that any injury or other traumetic event. The once. Building Contractor Self-employed 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumeme) Be 2 Albert A. Protenic Julia Mae Phillips 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 305 Kehm Road Saundra Protenic/Wife Queenstown, MD 21658 20b. Placa of Disposition (Neme of 20a. Method of Disposition Location - City or Town, State March 23, 1998 cemetery, crematory or other placa) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center | Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein, & Newnam Funeral Home JOHN R. MERCERON 408 South Liberty St. Centreville, MD2161 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Physiclan /Medical Immediete Cause (Final 1-3 years disease or condition resulting in death) Examiner Examiner The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last and usa as tha burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical Due to (or as e consequenca of): attanding signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? paga 2 should Completed 24a. Wes en autopsy performed? peen 20 No cartificata 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital lal or Attending Physician: The saftar death.

Il Director: After this cartificate ed in by the funeral director, pe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital tnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piaca, and due to the ceuse(s) end manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a, Certifier Medical complataly To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Lawrence D. Bohan, M.D.; 606 Dutchman's Lane, Easton, Md. 21601 32. Redistier's Signature State -Randelle Registrar

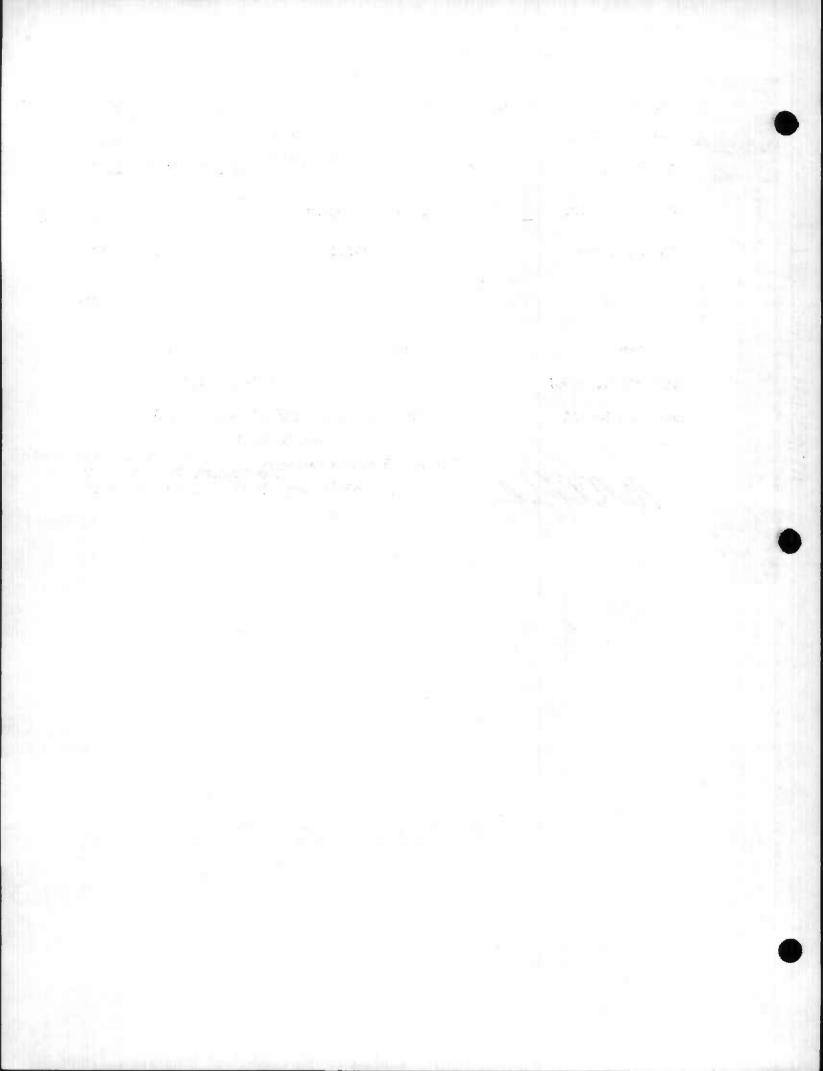


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Physician 2:40 Am Marshall. Kennedy Powell MARCH /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Hospital Lanham Prince George's | H Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 21, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral 1** M 2□ F Virginia 224 26 3982 75 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD P.G. Capitol Heights must be notified Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Opus Ave 20743 United States Funerai 12. Wes Decedent Ever in U.S.
Armed Forces?
1 DYes, 2 DNo 1943
If Yes, Give
Year or Dates: 1945 11. Maritei Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 7 is marked other than "natural", or iter traumatic event, the Medical Exeminer 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Clerk Grocery 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked off Marshall K. Powell Lessie UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Beatrice Powell 705 Opus Ave, Capitol Heights, 1Md 20743 20b. Place of Disposition (Nama of camatary, cramatory or other place March 24, 1998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cramation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Spacify) Cheltenham, Maryland Maryland Veterans Cemetery
22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service | Alexandria Ferry Road, Clinton, Md 20735 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death Physician Immediata Causa (Final disease or condition resulting In death) /Medical Careliac failure Examiner Examiner luid Overload The law requires that the death certificate be executed Sequentially list conditions, if any, laading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Last Due to (or as a consequence of): Box 68760, septicenia Physician/Medical Due to (or as a consequence of): use as the Part II. Other significent conditions contributing to death but not rasulting in the underlying causa givan in Part I. Records, P.O. 23b. Did tobacco usa contributa to the cause of death? Brain sten Sujardion 1 Yes 2 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 ₽ No this certificate 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Japatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 UN6 28a. Date of injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at W/A-Work? 28d. Describe how injury occurred After or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After a second of the funeral billing of the funeral billing of the funeral billing of the funeral billing of the funeral billing of the f 1 Naturai 5 Pending investigation N/A NA 1 Yes 2 No NIA 2 Accident 6 Could not be determined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide NIA NIA 1 Certifying Phyaician: To the best of my knowledga, death occurred at the time, data end place, and due to the causa(s) and mannar as stated.

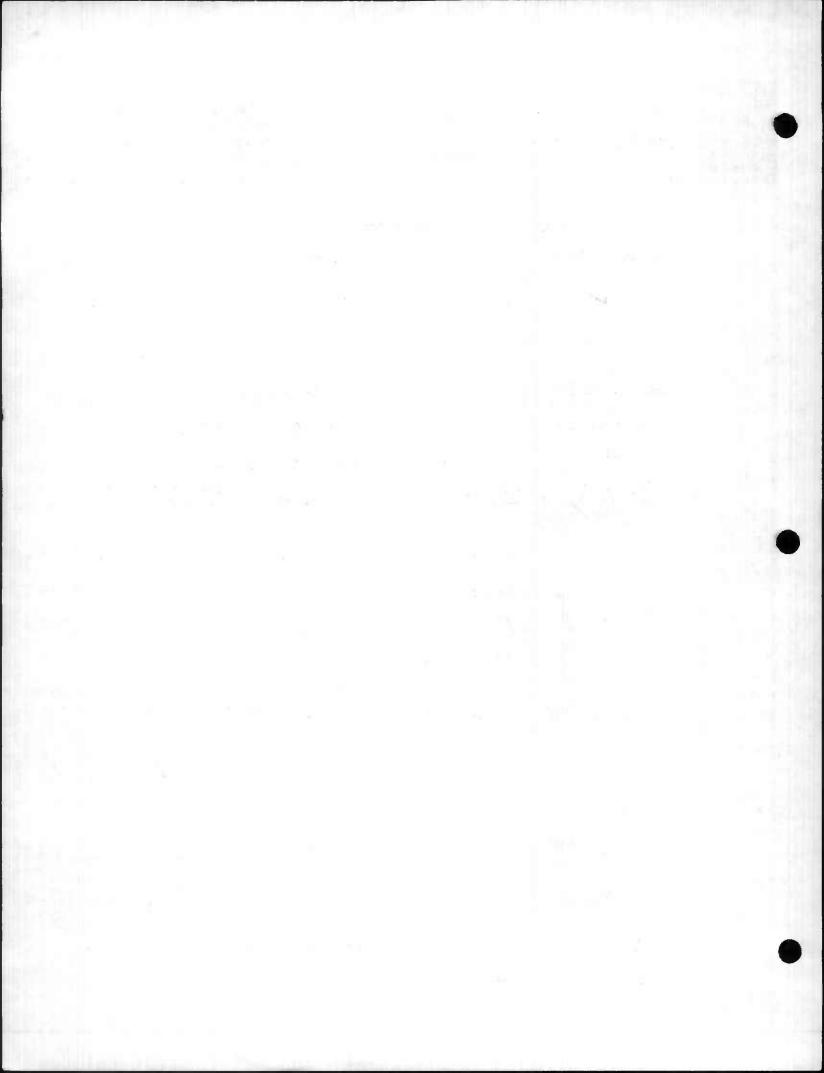
2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mein Sude Ms RS50574 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) MASTER SONDE, ND 6570 ICENTLUDRIH AVE SVITE LOD RIVERDALE, MD 32. Registrar's Signatura Day, Yaar) State MAR 2 5 1998

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 10465

					,	Certifica	ate of	Death		Reg. No.	10	1400			
	Dhombal		1. Decedent's Nama (First, Middla,	Lest)					2. Data of Do		Yaar	3. Time of Death			
	Physici /Medi		Dennis Milto	n Wilson	Riggl	eman			March		1998	5:05 am			
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	Funeral		5. Social Sacurity Number	3. Sax 7. A 1 → M 2 → F	ge (In yrs. las	Month	der 1 Year			rth ay, Year)	9. Birthp	laca (Stata or Foraign			
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	72 hours after death with the Maryland natural; or items 23s or 28s-f show orest Examiner must be notified at	Funeral Director	270 Main Stree	h-		101.									
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Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tu 2000.		21. Signatura of Funeral Sarvica Li	cansaa	1			ass of Facility							
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Division	or Attending Phattar death. Director: After th	Certification:	3 ☐ Sulcida 6 ☐ Couid no 4 ☐ Homicida determin	ad 288. Piece of in	jury - At homa	a, farm, straet, fact	tory, offica			Street end Num! wn, Stata)	per or Rura	l Routa Numbar,			
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Cartifying	Physician: To the best taminar: On the basis of	of my knowle	dge, daath occurre	ed at the t	ime, dete end piac	e, and dua to the	causa(s) and ma	anner as si	tated.			
	within 2 To the F complat		one)	and mannar st	ated.				Too at the time,	data arra prava,	0110 000 10	110 02000(0)			
	To Vitt	Σ	29b. Signature and title of certifler	~				sa number	, -	29d. Data signa					
	1		March 2								22,	1998			
	411		30. Nama and eddress of person w			Be) (Type, Print)									
	The		Tane Lil			ospital	Ca	nter.			_				
	Sta Registr		31. Dete filed (Month, Dey, Year) MAR 2 5 199	32. Registr	rer's Signature	a contract									

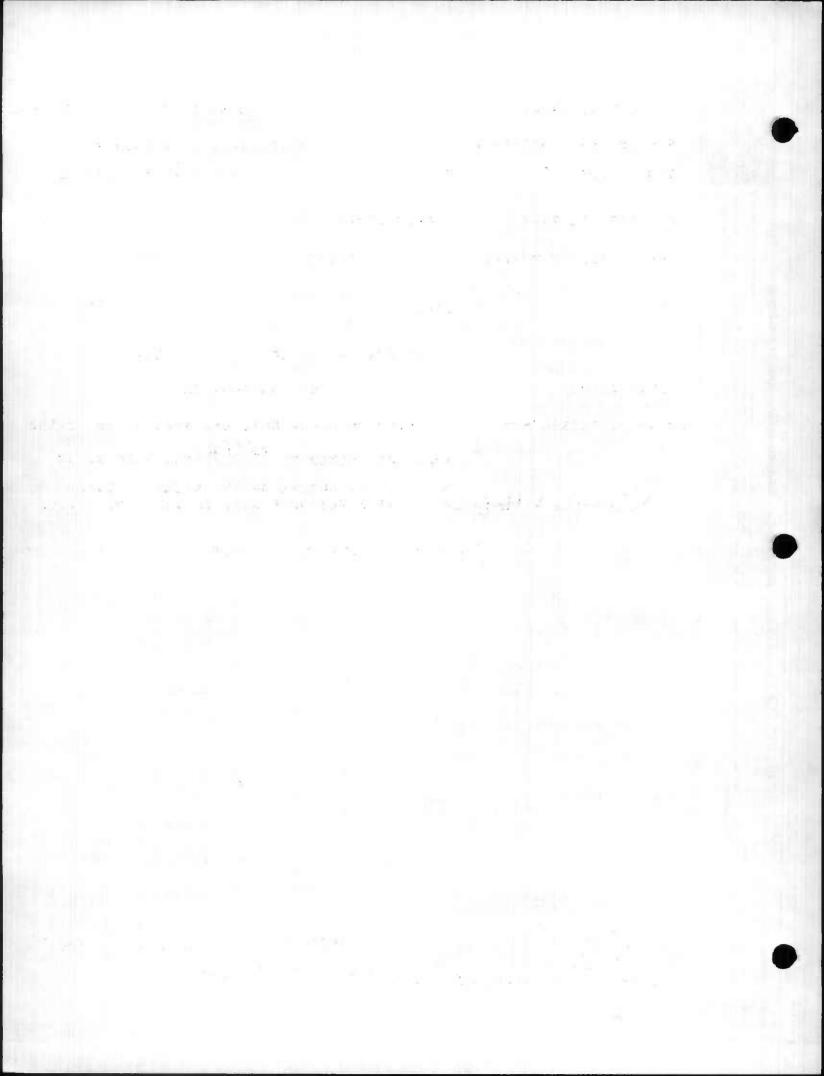


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dele of Death Month Dav **Physician** HAROLD J. RAYNOR March 22, 1998 2315 p.m. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SACRED HEART HOSPITAL CUMBERLAND

If Under 24 Hrs. 8 Date ALLEGANY If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 6 Sex **Funeral** Months Deys Hours MOM 20 F Director 213-22-2978 70 MAY 9,1927 MARYLAND Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City. Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND ALLEGANY CRESAPTOWN 10a. Citizen of What Country? 10e. Street end Number 10f. Zip Code With 14417 AMCELLE USA Funeral STREET 21502 death Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Stetus permit. Peges 1 and 2 should be filed within 72 hours effer of Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or hereay injury or other traument. Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Merried 2 Married altimore, Maryland 21215-0020 1946-1 Yes 2 No Specify: Specify: WHITE py 3 X Widowed 4 □ Divorced Yeer or Detes 1947 Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) SHIPPING-TUBE ROOM 8 TIRE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle Last) FLOYD RAYNOR OMI BROADWATER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) LONDY H. RAYNOR/SON 14703 MCMULLEN HWY, CRESAPTOWN, MD 21502 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Melhod of Disposition 20c. Location - City or Town, Stete MARGH IX Burial 2 ☐ Cremation 3 ☐ Removei from Stete 25,1998 CEMETERYFLINTSTONE, MD 4 ☐ Donetion 5 ☐ Other (Specify) ROCKY GAP VETERANS 21. Signature of Funeral Service Licensee 22. Name end Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LA VALE, MD 21502 Approximate Intervel Between Onset and Deeth **Physician** PHIMINARY CARCINOMATONIS Immediate Cause (Final /Medical disease or condition resulting in deeth) **Examiner** Examiner requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest buriel-tran Due to (or es e consequence of): end physician Physician/Medicai the Due to (or es e consequence of) 8 ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed peed page 2 1 Yes 2 No 1 Yes 2₽No certificete Division of Vital Hospital or Attending Physician: director, 25. Wes case referred to medice Be 28. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1. Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manper of Deeth Dete of Injury (Month, Dey Year) 28c. Injury af Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Naturel 5 Pending investigation Injun after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated. To the Hospi within 24 hou To the Funer completely fil edicai 29a. Certifier 29d. Dele signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier MARCH 23, 1998 8 30. Name and eddress of berson who completed ceuse of deeth (Item 23e) (Type, Print) DKNE cumbonano, mo 21012 914 VIRGINIA 6. MAGBOJOF MO 32. Registrar's Signeture 31. Dete filed (Month, Dev. Yeer) State MAR 2 4 1998 Registrar

DHMH 16 Rev 6/95

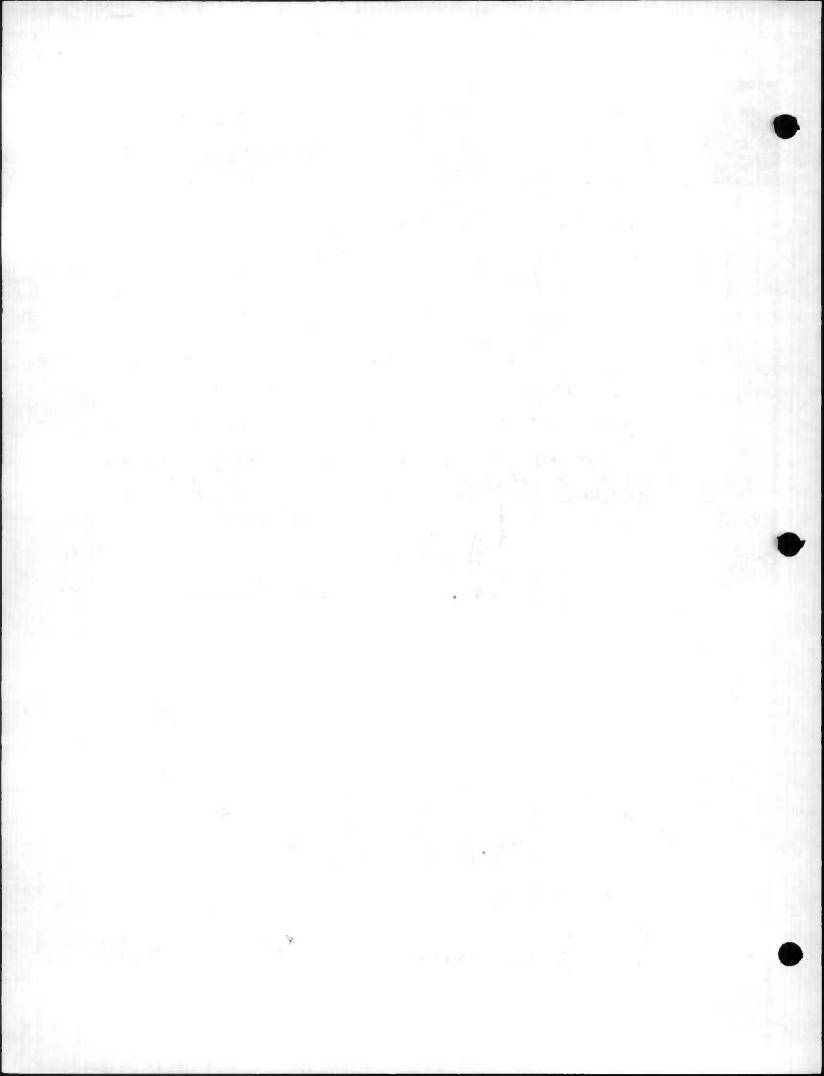


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State of Maryland / Department of Health and Mental Hygien 8 1 0 4 6 7

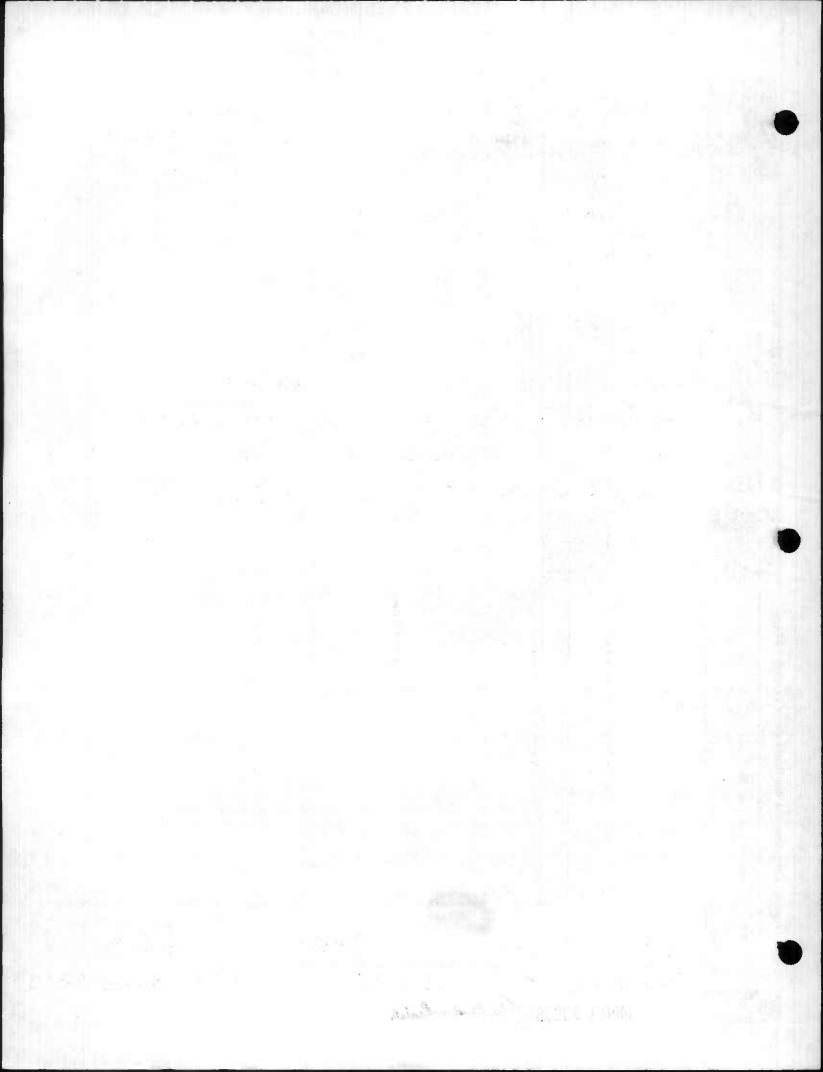
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	Exami		4a. Fecility Name (If not institution, give street and number)		ty, Town, or Location of Deat	h 4c. County of Deet	h
1			817 Roeth Ave	Cum	mberland	Allega	227
	Funeral		5. Social Security Number 6. Sex 7. Age (In year)	s. lest birthday) If Under 1 Year If U	ndar 24 Hrs. 8. Data of Bir	th 9. Birt	hpiece (Stete or Foraign untry)
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	yland W		10a. State 10b. County 10c.	City, Town or Location			10d. Insida City Limits
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	r 28	Director	10e. Streef and Number	10f. Zip Coda		10g. Citizan of What Co	untry?
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5-0020	72 hours efter death with the Maryland "natural", or Itema 23a or 28a-f show solical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Navar Marriad 2 ☑ Married 3 □ Widowed 4 □ Divorcad 12. Was Decedant Evar in Armed Forcas? 1 □ Yas 2 ☑ No If Yas, Giva Yeer or Datas:	If Yas, specify Cuben, Ma	lc Origin? (Specify Yas or No xican, Puarto Rican, etc.) ecify:	14. Raca - Ame Bieck, White Specify: White	e, atc.
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Maryland	d 2 should th and Mer 7 is marks traumatic		19a. informant's Name/Raiationship (Type, Print)	19b. Mailing Addrass (Street and N	lum <i>ber or Rural Routa Nu</i> m <i>b</i>	er, City or Town, State, 2	(ip Coda)
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altimore,			20a. Mathod of Disposition 20b 1	. Piace of Disposition (Nama of camatery, cramatory or other place)	Deta	20c. Location - City or	Town, Stata
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Ball	permit. Departi	-	21. Signatura of Funeral Savice Linesee	22. Nama and Addrass of F	acility Kight Fu	neral Hom	e 21502
ш	205 # g	1	with my	309-311 Dec	catur St.,	Cumberland	d, MD
4	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to	(or as a consequence of):	2 2 200		Approximata Interval Batween Onsat and Death
Box 68760,	deeth certificeta be executed e ettending physician end of for use es the bunal-transit	in/Medical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	(or as a consequance of): (or as a consaquanca of):			
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of Vital Records,	aw requi	Completed			24a. Was	omed?	Wara autopsy findings available prior to complation of cause of death?
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Ħ	Physician: The rhis cartificate rail director, pa	o Be	25. Was casa rafarred to madical axaminar?	Other	Placa of Daath (Check only		
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	e Hospit 24 hour e Funera	edicai	29a. Cartifiar (Check only one) Certifying Physician: To the basis of my kill Medical Examiner: On the basis of axamilend manner stated.	nowiadga, daath occurred at tha tima, dat nation and/or invastigation, in my opinion,	ta and placa, and dua to tha , daath occurred at tha tima,	causa(s) and mannar as data and placa, and dua	stated. to the causa(s)
	within To th	Me	29b. Signatura and title of cartifiar	29c. Licansa num	ber	29d. Data signed (Mont)	n, Day, Year)
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			30. Nama and missess of person who complated causa of death (It	am 23a) (Type, Print)		-1,11	
	Yras		Guy Fiscus, M.D., 500 Men		, Cumberlan	d, MD 2150	02
	Sta	ite	31. Data filed (Month, Day, Yaar) 32 Pegistrar's Sig				

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State of Maryland / Department of Health and Mental Hygiene 8 10168

				100		Certificate	of	Death			Reg. No	20		0400
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À.	Exami	ner	4a. Facility Name (If not Institution, give street and number) 4b. City, Town									4c. County of Deeth		
⊢	11 300		Westminster Nursing Center Westminster Carroll 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore											
	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural;, or items 23a or 23a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		5. Social Sacurity Number 6. S 216–16–4558 1 Usual Residence of Decedent	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Bird (Month), De Jan 1					ey, Yeer) 9. Birthpiace (State or Foreign Country) Md					
			10a. State 10b. County		10c. City, Town	or Location								10d. Inside City Limits
		Director	Md Howard	ville						1 ☐ Yes 2 No				
		ral Dir	2149 Rt. 97		10f. Zip Code 21723					10g. Citizen of What Country? USA				
Maryland 21215-0020		by Funeral	11. Maritai Status 1□ Never Married 2□ Married 3□ Widowed 4□ Divorcad	12. Was Decedent Ev Armed Forces? 1 Types 2 □ No If Yes, Give Yaar or Dates:	Tred Forces? Yes, 2 No 1941- Yes, Give 1942			ent of Hispanic Origin? (Specify Yas or Ni ify Cuban, Mexican, Puarto Rican, etc.) □ □ No Specify:				14. Race - Amarican Indian, Black, White, etc. Specify: White		
		Completed	15. Decedent's Ed (Specify only highest gra- Elemantary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry				
		Con	12	Coilaga (1-4or 5+)	farmer						griculture			
		To Be	17. Father's Neme (First, Middle, Last) William Brice Ric		18. Mother's Nama (First, Middl Louise Wolf					e, Maidan Sumama)				
			19a. Informant's Neme/Relationship (Type, Print) Carol Ann Clark (daughter) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13383 Pipes Lane Sykesville, Md. 21784									o Code)		
altimore,			20a. Method of Disposition 1 ★ Buriai 2 □ Cremation 3 □ 4 □ Denstion 5 □ Other (Cree)	Removal from State	20b. Ptace of D camatery,			isposition (Name of crematory or other placa) EW Cemetery				20c. Location - City or Town, Sta Marriottsville,		
Baltii			4 Donation 5 Other (Specify) Mt. View Cemetery 3-20-98 Marriottsville, Md 21. Signature of Funeral Sarvice Licansee (4) 22. Name and Address of Facility Haight Funeral Home & Chapel										·	
	20244		P.O. Box 195 Sykesville, Md. 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximate											
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequenca of): Athres clushic disease Due to (or as a consequenca of): Due to (or as a consequenca of): Due to (or as a consequenca of):										Syears Oytag	
Box 68760,	seath certrificete be executed ethending physicien end for use as the buriel-transit	Medical	cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last	ua to (or as a co	consequance of):									
of Vital Records, P.O.	death c e ettended for us	Icla	Part tl. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I.								23b. Did tobacco use contribute to the cause of de			
	or Attending Physician: The law requires that the fiver death. Her death. Pifector: After this certificate hes been signed by the lin by the funeral director, pege 2 should be deteched by the funeral director, pege 2 should be deteched.	by Physician	(embra / VA						_/				bably 4 Unknown	
		Completed b						24a. Was	24a. Was an autopsy performed?			ere autopsy findings allable prior to impletion of cause death?		
		шо								10	Ves 2	DNo		☐Yes 2☐No
		Bec	25. Was case referred to predical 28. Piece of Deal											
		To	examiner?		ome 5 ☐ Residenca 8 ☐ Other (Specify)									
			27. Manner of Death 1 ☑ Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of tnjury M 28c. Injury at Work? M 1 Yes 2 No										
5		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - At home, farm, street, factory, offica building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				al Route Number,	
	To the Hespital or Attent within 24 hours efter deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										stated. the cause(s)	
	within To th	Me	29b. Signature of titte of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)									Day, Year)		
,			30 Neme and address of person who co	0 /	th (ttem 23e) (T	ype, Print)		2	, ,	2115	7	R	110	F. Foxst, Mi
	Sta Registr		31. Date filed (Month, Dey, Year) MAR 1 9 199	32 Registrar's	NCS fyn Signature	ins fere	-/-	ary/	930	01137	f-a	18	ul t	- TOKST ILL
	riegisti	ui	MAR 1 9 199	10 July will	WALLES OF	tall,								



State of Maryland / Department of Health and Mental Hygiene \(\text{\text{\$\gamma}} \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARCH 18, 1998 1500 Elsie M. Strong 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Cumberland
If Under 24 Hrs. B. Date
Hours Min. (Mon. Sacred Heart Hospital Allegany If Under 1 Yeer Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Deys 1 M 25 F Months 83 Yrs 5-12-1914 Maryland 10d. Inside City Limits 10c City Town or Location 10h Counts 1 Yes 2 No Allegany Westernport 10f. Zip Coda 10g. Citizen of Whet Country? 21562 100 Spring Street USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 20 No If Yes, Giva Year or Dates: 14. Rece - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 N Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Textile Production Worker 11th Grade 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elkany Likens Cora Belle Bobo 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Husband Strong, Sr 100 Spring St., Westernport MD 21562 Richard W. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Peter's 3/21/98 Westernport 22. Name end Address of Fecility Fredlock Funeral Home 21. Signature of Funerel Service Lieu Piedmont, WV 26750 23a. Part1. Entar tha disaasa, or complications that caused in shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, Approximete Interval Between Onset end Deeth TE Dua to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 Yes

Physician - /Medical Examiner

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nati of Haelih and Mental Hygiens.
That if Hem 27 is marked other than "natural", or items 23s or 28s-f ahow mix if item 27 is marked other than "natural", or items 23s or 28s-f ahow mix if items and items of the notified all mix or other traumatic event, an Madesil Examine matter and items of the notified at

Baltimore,

/Medical

5. Social Security Number

10e. Street and Number

20a. Mathod of Disposition

Immediata Causa (Final disease or condition resulting in deeth)

10a State

MD

11. Maritei Status

Director

Funeral

by

Completed

Be

214-07-3983 Usual Residence of Decedent

Examiner physician and tha buriel-transit Physician/Medical signed by the a d be dateched þ Completed cartificata has b Be funaral Certification:

law requires that the death certificate be executed

Attending Physician:

after death Director:

To the Hospital or A within 24 hours after To the Funeral Direcomplataly filled in b

6

State Registrar

Medical

Division of Vital Records, P.O. Box 68760,

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. PER TENTION IABETES MELLITES ONGESTVE HEART HAILURE 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpetlent 3 □ DOA

24a. Wes an eutopsy

24b. Were autopsy findings evallable prior to completion of ceuse

	axaminer?		medicei	
_	Manner of	Death	7 Panding	

28a. Date of Injury (Month, Day Year) 5 ☐ Panding investigation 6 Could not be detarmined

28b. Tima of

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD 21532

29a. Cartifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar asted. and manner

29b. Signeture and title of certifier UMP 29c. License number

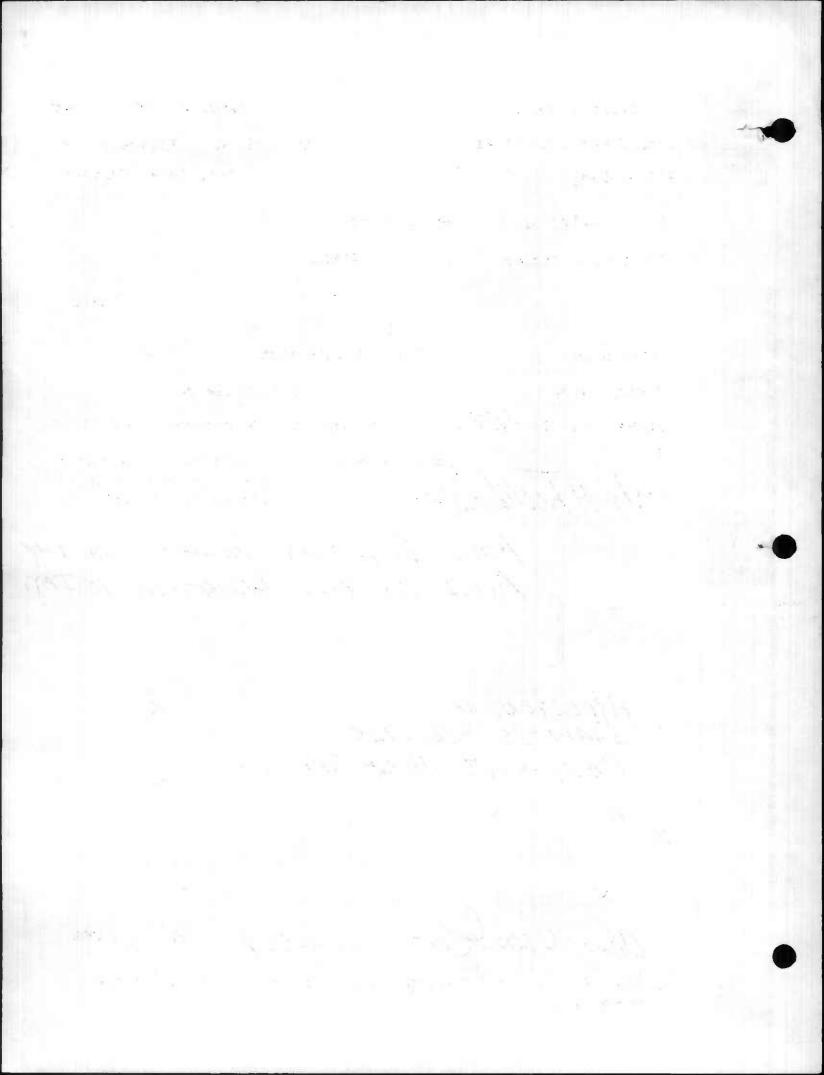
29d. Date signed (Month, Day, Year)
MARCH ic., 1998 MARCH 19.

completed ceuse of death (Item 23a) (Type, Print)

48 Tarn Terrace

Year) 1998

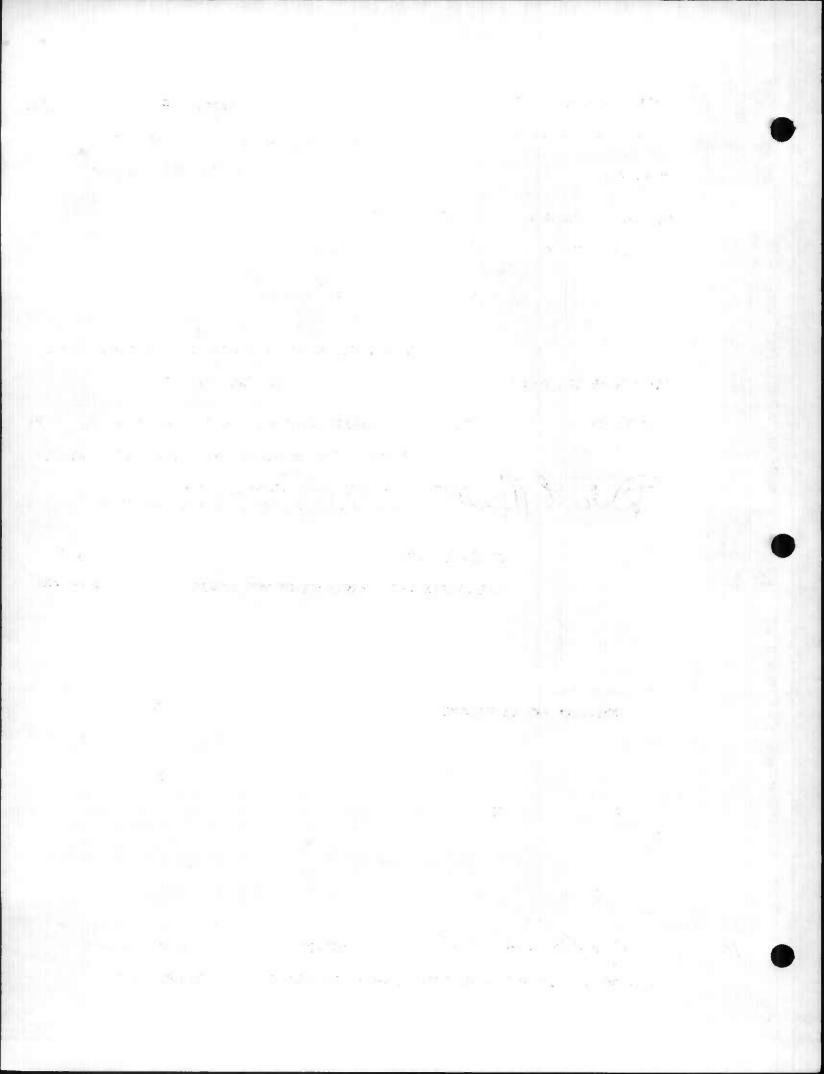
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of	Death			Reg. No.			
	Physician	Decedent's Name (First, Middle Community)								2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medical	IMKI BOROTHI								MARCH	18 19		12:05PM	
Ä	Examiner	44 Facility Name (If not institution SACRED HEART H		um <i>ber)</i>				46. City, To CUMBEI		ocation of Deat D		of Death		
	Funeral							8. Dete of Bir (Month, De	Sirth 9. Birthplace (State of Country) 1915 MARYLAND					
L	Director	212-38-7320 San Pris. JAN 26 1915 Mark 26 191								MARY	LAND			
	Aerylend f show ed st	10a. State 10b. County	EGANY		ity, Town or Lo								10d. Inside City Limits 1 Yes 2 No	
	with the Mer a or 28a-f a be notified					10f. Zip	Code 150	2			10g. Citizen of U.S.	Whet Cou	untry?	
	na 23	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decede	ent of I	lispanic Orl	lain? (Sp	ecify Yes or No	- 14. Ra	ca - Amer	ican Indian,	
21215-0020	s 1 and 2 should be filed within 72 hours efter deeth with the Merylend Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examines must be notified at To Be Completed by Funeral Director	11. Marital Status 11. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, 2 No If Yes, Give X Year or Dates:				er in U,S. 13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerlo Ric					Specif	ck, White by: WH	te, etc. HITE	
5-0	72 ho	15. Deceder (Specify only highe	it's Education	()	16a. Dece	dent's Usual kind of work	Occup	pation during mos	t of work	dna	16b. Kind of B	iusinass/l	ndustry	
121	ed within 72 ho ygiene. Ar than "natura it, the Western Completed	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT us	retire	d)			N TEAC	UTNO	SCHOOL	
42	Hygiene. Hygiene. ther than ent, the				ALLEGA	ANI CO	• D	1		EDUCATIO	Meiden Sumar		SCHOOL	
Maryland	Alaryland 2 should be file and Mental H 1s marked out summit even To Be	TAMES BANDOLD								JANE BUI		,		
lany	2 shot and N ls mail	19a. Informent's Name/Reletions	ship (Type, Print)		19b. Meili	ng Address	Street	and Number	er or Au	ral Route Numb	er, City or Town	, State, Z	ip Code)	
	1 and 2 Health em 27 I	JAMES L. SMITH		SON				ROAD	N.E.				AND 21530	
Baltimore,	00	20a. Method of Disposition 1 We urial 2 Cremation 4 Donation 5 Other (S		State	Place of Dispo cemetery, creat LLCRES	metory or of	ner pla		CH 2	Date 20 1998	20c. Location CUMBERI		MARYLAND	
Balt	permit. Pag Department Important: h any injury o othos.	21, Signature of Funeral Service	Licensee M	SH	-	2. Name and ERRITT				RAL HON	1E			
		23a. Part 1. Enter the disease, or	complications that	caused the dea	th. Do not en	04 DEC	ATU of dyi	R_STR	EET cardiac	CUMBERI or respiratory a	AND MAF	RYLAN	Approximate	
8	Physician	shock, or heart failure. List	only one cause on	each line.									Interval Between Onset end Death	
П	/Medicai	Immediate Cause (Final disease or condition LIVER FAILURE									l week			
	Examiner	resulting in death)	е		or as a conse	quenca of):								
	is de		ь. М	ETASTAS	IS FROM	1 CARC	INC	MA OF	THE	BREAST	[6 months	
	executed in and iel-transit	Sequentially list conditions, if any, leading to immediate												
68760,	siciar siciar b buri													
×	certificate be executed ding physician and se as the buriel-transit	resulting in death) Last Due to (or as a consequenca of):												
Bo	et the death cert d by the attendin etached for use	David Other designation and dist			41 1 4			and Badd		005 014	A.A		to the sever of death	
0	thet the de ed by the detached	Part II. Other significant condition				noenying ca	use gr	ven in Part	l.		Yes 2 No		to the cause of death obably 4 Unknow	
S, P	5 60		Y ARTERY	DISEASE						, ,	29410			
Records,	been s should									24a. Was	an autopsy ormed?	8	Were autopsy findings available prior to completion of cause of death?	
Ä	The law page 2									10	Yes 2X No	1	□Yas 2□No	
Vital	certificate rector, pag		1				-11-y	26. Place	e of Dea	th (Check only	one)			
of V	2 0 0	1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatie		1		ursing He	ome 5 Res	denca 6 □Ot	her (Spec	eify)	
	Affer thi funeral tion: 1	27. Manner of Death 1 XNatural 5 Pendir	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o Injury		c. Inju Wo	rk?		28d. Describe	how injury occu	rred		
Division	Attender deet by the	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At I		M reet, factory		Yes 2	No		Street and Num wn, State)	ber or Ru	ral Route Number,	
	Hospi 24 hour Funer stely fill		ng Physician: To the	e best of my kn basis of examin- nner stated.	owledge, deat etion end/or in	n occurred a vestigetion,	t the ti	me, date an opinion, dee	nd place, oth occur	and due to the	cause(s) and m	anner as , and due	stated. to the cause(s)	
	Within 2 to the comple	29b. Signature and title of certifie		THIOI SIGNOG.		29c.	Licen	se number		-	29d. Date sign	ed (Month	n, Day, Year)	
	10	► C. J. V	needs	ma).	1	174	7474 MARCH 19			19 19	998		
	MI	30. Neme and eddress of person CLARENCE J.					.VE	CUMBI	ERLA	ND MARY	LAND 2	1502		
	State Registrar	31. Date filed (Month, Day, Year)	The Section of the Contract of	Registrar's Sign	orum Hardwill				-					

DHMH 16 Rev 6/95

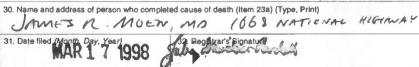


State of Maryland / Department of Health and Mental Hygiene

												Reg. No.			
sician edical	1. Decedant's Nama (Fi	First, Middla, M .		SAGER							2. Date of De		1998		ne of Death
miner	4a Facility Name (If not							4			ocation of Deat		unty of Deat		
	SACRED H 5. Social Security Numb		HUSE 6. Sex	-	a /la ure	last birthday)	If Under	r 1 Yaar	if Under		LAND		LEGA		ate or Foreign
tor	214-05-76. Usual Residence of Dec	33	1□ M 2	HP - F	91	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 1	5,1906	WEST	VIR	ate or Foreign
foer must be notified at		Db. County	GANY			y, Town or Lo									de City Limits Yes 2 \(\subseteq \text{No}
Olrec	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Co	untry?			
<u>6</u>	118 S. SM	IALLWO	OD STR	EET			_	1502				U.S			
by Funeral	11. Marital Status 1 □ Naver Married 3 ☑ Widowed 4 □	d 1 If Y	2. Was Decedent Evar in U,S. Armed Forcas? 1 Yes, 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☒ No Specify:				ecify Yas or No Rican, etc.)	cify Yas or No- Rican, etc.) 14. Race - A Black, V		merican Indian, /hite, atc. HITE		
	15.	. Decedent's	Education grade comp	oleted)		16a. Dece	dent's Usu	al Occup	ation du <i>ring</i> mos	at of work	ina	16b. Kind	of Business/	Industry	
Completed	Elementary/Secondar UNKNOWN			llege (1-4or 5	5+)	0.00	kind of wo DO NOT U)			HO	ΜF		
	17. Father's Name (Firs	st, Middle, Li	ast)			****	A4 M. 34 V.		18. Mothe	er's Nam	e (First, Middle				
o Be		LANTZ							SAR	AH	SEE				
_	19a. Informant's Name	/Relationshi	ip (Type, Prir	nt)		19b. Maili	ng Address	s (Street	and Numbe	er or Rui	rai Route Numb	er, City or To	own, State, 2	ip Code)	
	ZETTA S.	SCARLI	ett /	DAUGH					STRE	ET,	CUMBERI	AND, I	MD 21	502	
	20a. Mathod of Disposit 12 Burial 2 Co 4 Donation 5	ramation 3		I from Stata	C	Place of Disponentery, cre	matory or o	other plac		3	Date /15/98		ion - City or		te
suce.	21. Signature of Funera										, ,				
a	Shord	v 91	Los	chere	C the deat		202 G	nd Addras RCH I	ss of Facilit FUNER E ST.	AL H	OME, P.	A. ID, MD	2150		rimata
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29b. Signature and titia of certifier

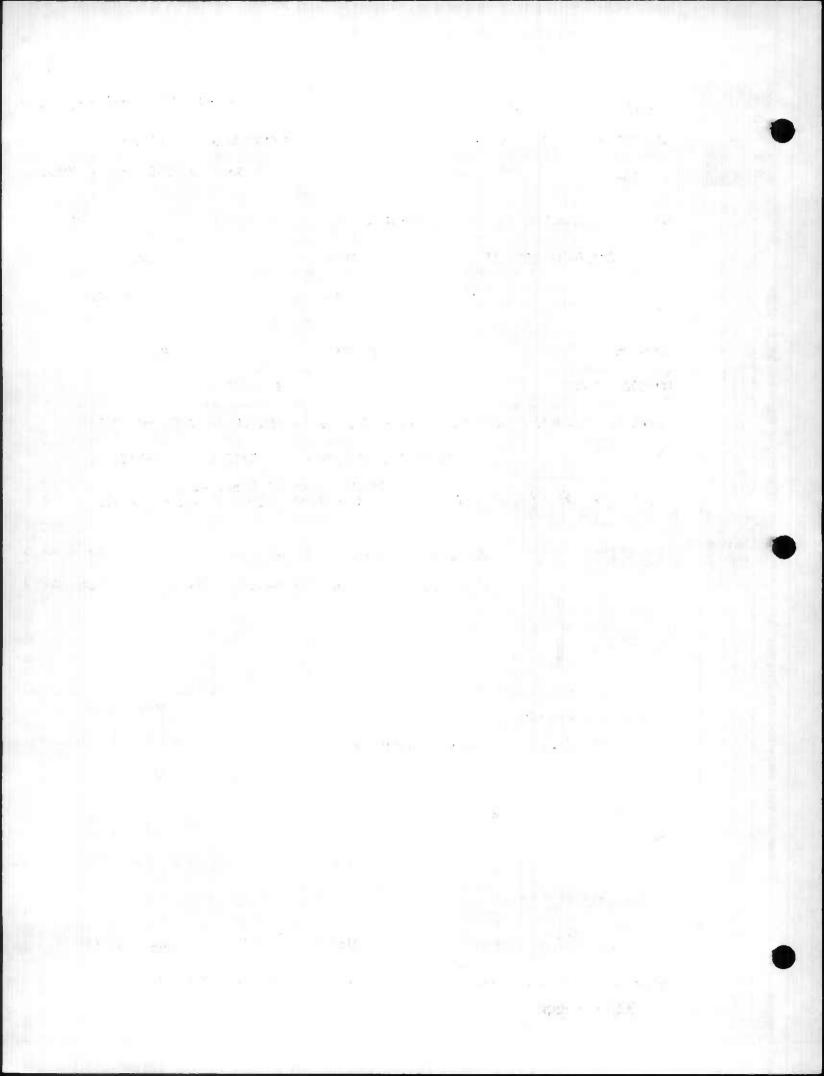


29c. License number (MO)

29d. Date signed (Month, Day, Year) MARCH 13, 1998

LAVALE, MAKYUND

State Registrar



Amended #1067. Mls. 3/10/98, Allegang Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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ite	of Maryland	1/D	epartment	Oī	Health	and	mentai	ну	gie
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altimore, injury or permit. Pege Department o Important: If that the death certificate be executed buriel-transit pue physician the 88 eşn 50 ed by the e P.O. been signed by should be detec Records, certificate Division of Vital Hospital or Attending Physician: this funeral After efter deeth. Director: Aft To the Hospital or within 24 hours aft To the Funeral Di completely filled in 5

Reg. No. 2. Data of Daath 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARCH Patsy Jean Scharf 12 1998 0557am /Medical 4a Facility Name (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 1 F Director 219-34-7287 Aug. 31, 1937 MD Usual Residenca of Deceden the Maryland 10b. County H/1 egan y Cumberland 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itema 23s or 28s-1 show the Medical Examiner must be notified at 1 √Yes 2 No Maryland Cumberland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 640 Bedford Street 21502 USA death 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yas 2 🕅 No If Yes, Give 1 Nevar Marriad 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Nidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) lel Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Hairdresser Beauty traumetic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fill ment of Health end Mentel H ant: If item 27 is marked oth Thomas Lancaster Anne Belle (Oates) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. informant's Name/Relationship (Type, Print) Rodney L. Oates 640 Bedford St., Cumberland, MD 21502 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlat 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory! 4 ☐ Donation 5 ☐ Other (Specify) 3/13 Smithsburg, 22. Name and Address of Facility 309-311 Decatur St. 21. Signature of Funeral S Cumberland, MD 21502 Kight Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each lina. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 36 Hours P8.5 disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner TOR - COLON TOTICE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown inser's py 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No CND STRUE SNA 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Naturai 2 Accident 5 Pending invastigation 1 Tyes 2 No 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medicai

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State Registrar 29b. Signature and title of certifie

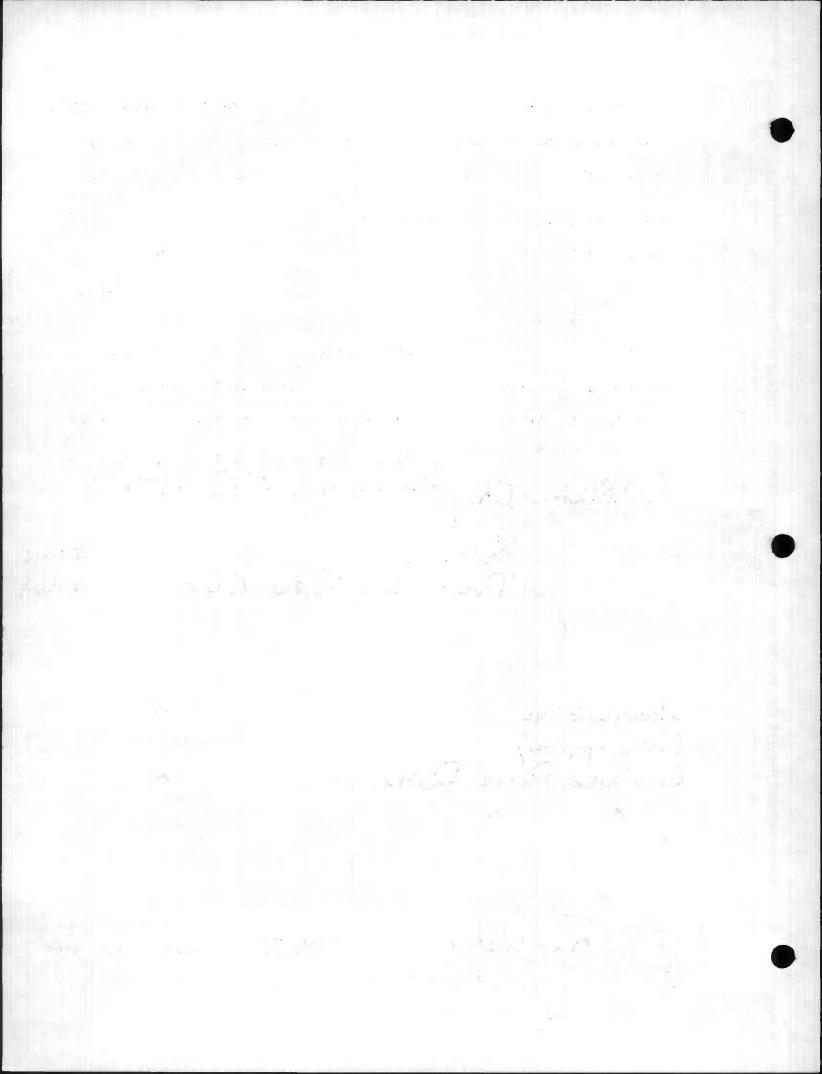
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29c. License number

29d. Date signed (Month. Dav. Year)

12 1998 MARCH

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Welik 902 Seton Drive Cumberland MD hobert 72. Registrar's Signature 31. Date filed (Month, Dey, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 | 01, 73 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month ERCIL LOY STUMP 1998 MARCH 10 1:15 P. M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country)
WEST VIRGINIA 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Yrs. Director 220 10 0354 AUG 15 1915 Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sh must be notified MARYLAND ALLEGANY FROSTBURG Director 1 ☐ Yes 2 Ñ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 16702 OLD NATIONAL PIKE, SW 21532 U.S. Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married ŏ by 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) .. Peges 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 Is marked other th lury or other traumatic event, in 8 WELDER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRISON JEROME STUMP SARAH LOUISE MESSENGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 Is any Injury or other traignts. EILEEN DUNCAN / FRIEND 12110 EMMETTDALE LANE, FROSTBURG, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 3/13/98 ECKHART CEMETERY ECKHART, MD 21. Signature of Funerel Service Lidenses 22. Name end Address of Facility
SOWERS FUNERAL HOME, P.A. Lowers 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert tailure. List only one cause on each line. Approximete **Physician** /Medical Immediate Cause (Final 11 RemIA 48 HOURS disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence ot): Physician/Medicai Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pag I. 23b. Did tobacco usa contribute to the cause of death? Old intracerebral infanci Right Hemplegia ate hes been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings eveileble prior to completion of cause of death? Be Completed 24a. Was an eutopsy performed? CONGESTIVE HEART FAILURE certificate hes PLEURAL 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese reterred to medicel 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After t 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Thomloide

Box 68760, P.O. Division of Vital

21215-0020

Baltimore, Maryland

The law requires that the death certificate be executed Attending s after dea. To the Hospital or within 24 hours at To the Funeral D

THUS State

Medical

29a. Certifier

29b. Signature end title of certifie

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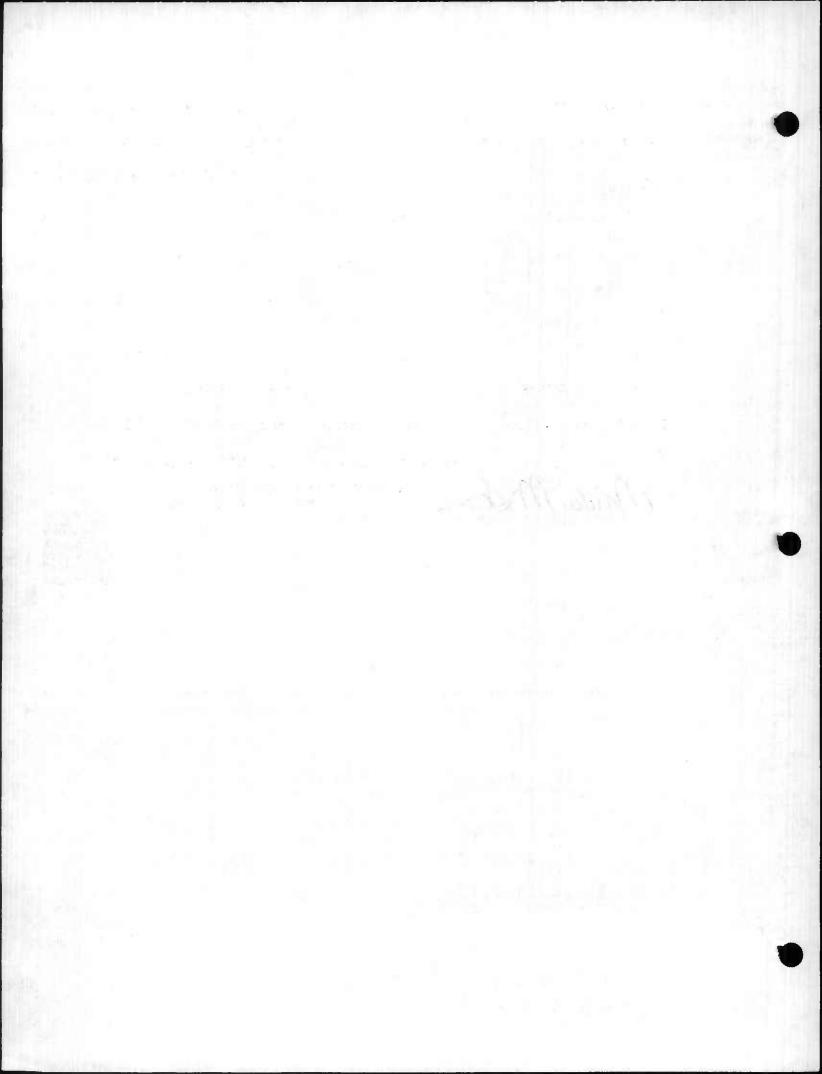
30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) PLAZA FROSTBURZ, Maryland 21532 CHANTS MO Rt36 FROSTRUME

29d. Date signed (Month, Day, Year) march 11, 1998

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner stated.

29c. License number

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** March 21, 1998 eation of Death 4c. County of Death Margaret E. Snapp /Medical 6:15AM 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death Examiner Collingswood Nursing Home Rockville Montgomery If Undar 1 Year 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign Country) New Hampshire **Funeral** Days 1□ M 2□ F Months Hours Yrs. Director 579-60-4726 99 Jan. 15,1899 Usual Residence of Decedent 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Marilan Exercises mainton notified as 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Funeral #7 Barclay Court 20850 U.S.A. 12. Was Decedant Evar in U.S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, White, atc. 1 Yas 2 No 1√2 Navar Marriad 2 Married 1 Yas 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Yaar or Datas: Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coilega (1-4or 5+) 12 Internal Revenue Serv. Accountant 17. Fethar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middia, Maidan Surnama) John W. Snapp Mary E. Deckard

19b. Mailing Addrass (Streat end Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ratationship (Type, Print) David R. Gibbs/ Nephew #7 Barclay Ct. Rockville, Md. 20850 20b. Place of Disposition (Nama of cematary, crematory or other piaca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Cedar Hill Cemetery 3/25/98 Suitland, Md. 22. Nama and Addrass of Facility Lee Funeral Home 6633 Old Alexander Ferry Rd. Clinton, Md. 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. **Physician** a. PONGESTIVE FAILVRE

Dua to (or as a consequence of):

b. ARTPRIOSCUEROTIC OARDIO VASCULAR

Dua to (or as a consequence of): /Medical Immediata Causa (Final disaasa or condition rasulting in daath) **Examiner** Physician/Medical Examiner pital or Attending Physician: The law requires that the death certificate be executed ours after deeth.

The second of the certificate has been signed by the attending physician and filled in by the functal director, page 2 should be deteched for use as the buriel-fransit filled in by the functal director, page 2 should be deteched for use as the buriel-fransit Sequentially list conditions, if any, laeding to Immediata causa. Enter Underlying Causa (Disaase or Injury that initiated events resulting in death) Last DISTASE Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 3 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wara autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Pieca of Death (Check only one) 1 Yas 2 No Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 28e. Dete of tnjury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Naturel
2 Accident 5 Panding invastigation 1 Yas 2 No 6 Could nof be datarminad 3 Suicida 28f. Location (Streat end Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Scriffying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, end due to the cause(s) and manner stated. Medical 29a. Certifian 29b. Signature and this of perimed 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

Walter E. Goozh, M.D. 32. Registrar's Signatura

1299 Lamberton Drive, Silver Spring, Maryland 20902

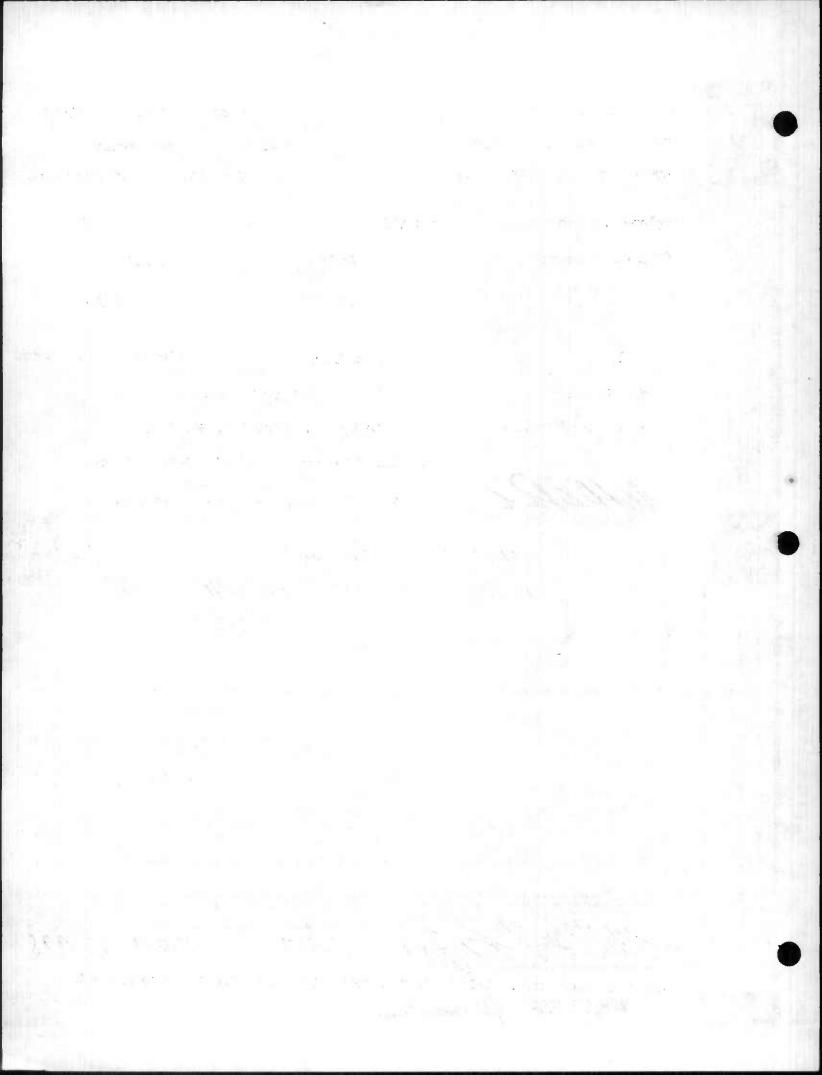
30. Name and addrass of person who completed cause of death (ttem 23a) (Type, Print)

Maryland 21215-0020

Baltimore,

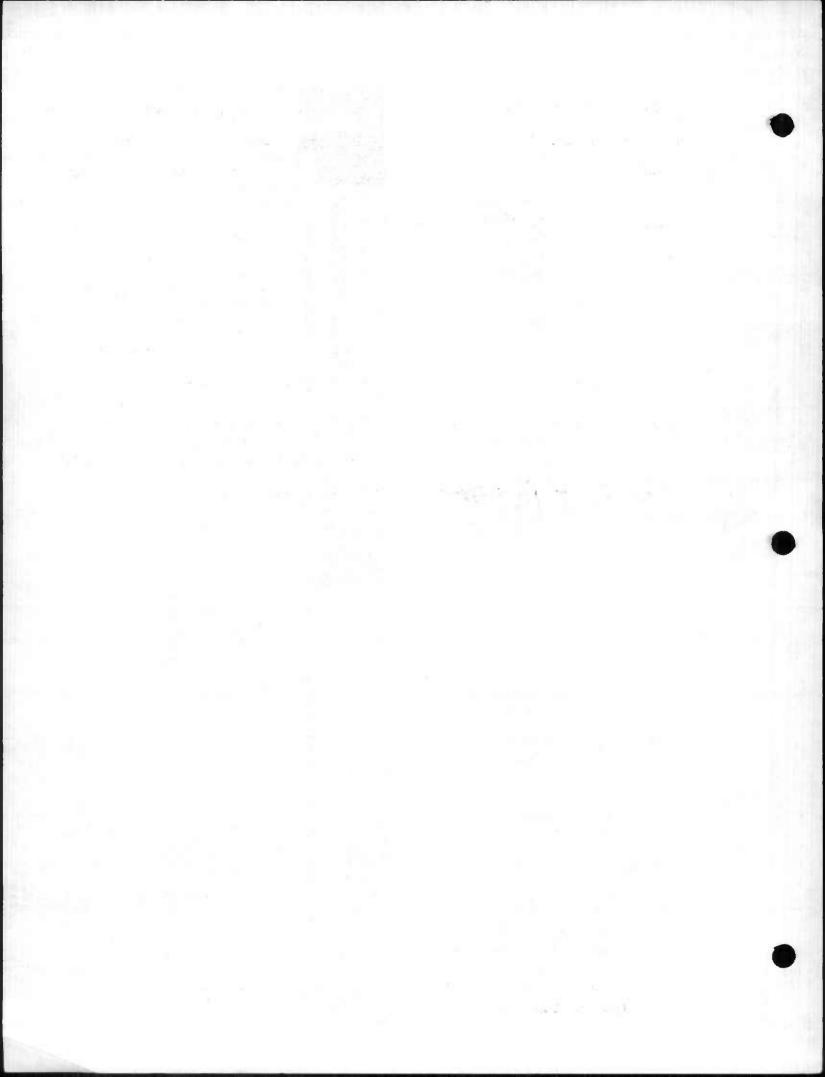
P.O. Box 68760,

Division of Vital Records,



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Year EDWARD ROLAND TAYLOR 14:44PM March, 13 1998 /Medical R. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY | If Under 1 Yeer | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Min. | MAY 7 1 913 5. Social Sacurity Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1√ M 2□ F 214-07-5251 84 Yrs Director W. VA. Usual Rasidance of Decedani permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 28 or 288-1 show any injury or other traumetic event, the Medical Exercises. 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Q Yas 2 □ No Director MARYLAND ALLEGANY CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 526 AVONDALE AVENUE 21502 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No if Yas, Giva Yaar or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - Amarican Indisn, Bieck, Whita, atc. 1 Navar Married 2 X Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada com 16b. Kind of Businass/Industry rada completed) Eiemantary/Secondary (0-12) Collaga (1-4or 5+) SPINNING DEPT. CELANESE CORP. 17. Fsther's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meldan Sumama) EDWARD MALCOM TAYLOR EDNA LOUELLA POST 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MARY ANNA TAYLOR WIFE 526 AVONDALE AVE. CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Nama of cemetary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from Stata HILLCREST CEMETERY MARCH 16 1998 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Addrass of Facility MERRITT-ADAMS FUNERAL HOME 23a. Pert1. Entar tha disaasa, or complications that caused tha daath. Do not anlar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart fallura. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medicai Immediata Cause (Finel Obstructive lung disease disaasa or condition resulting in daath) Examiner Examiner physiclan and the burial-transit Sequantially list conditions, if eny, laading to immadiate causa. Entar Underlying Cause (Disaese or Injury that initieted evants rasulting in death) Last Dua to (or as e consequence of): Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): usa jo signed by the a d be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 ☐ Unknown eart Failure þ 24a. Was en autopsy performed? 24b. Wara autopsy findings evelleble prior to Completed peen reflux esophagitis completion of cause of death? has Renal Failure Fracture cartificata 1 Tes 200 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: after death. Director: After this carifica 25. Was casa refarred to medical axaminer? Be 26. Place of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 Inpetient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturai 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28e. Piece of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) completely filled in by 4 Homicida To the Hospital of within 24 hours a To the Funeral D 29a. Certifiar Medical KCertifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signetura end titia of certifier 29c. Licensa number 29d. Deta signed (Month, Day, Year) 30. Nama and eddrass of person who complated cause of deeth (Item 23e) (Type, Print) DR SIKANDER L. SANDHIR 48 TARN TERRACE FROSTBURG, MARYLAND 21532 31. Data filed (Month, Day, Year) MAR 1 6 Hagistfar's Signature State Registrar



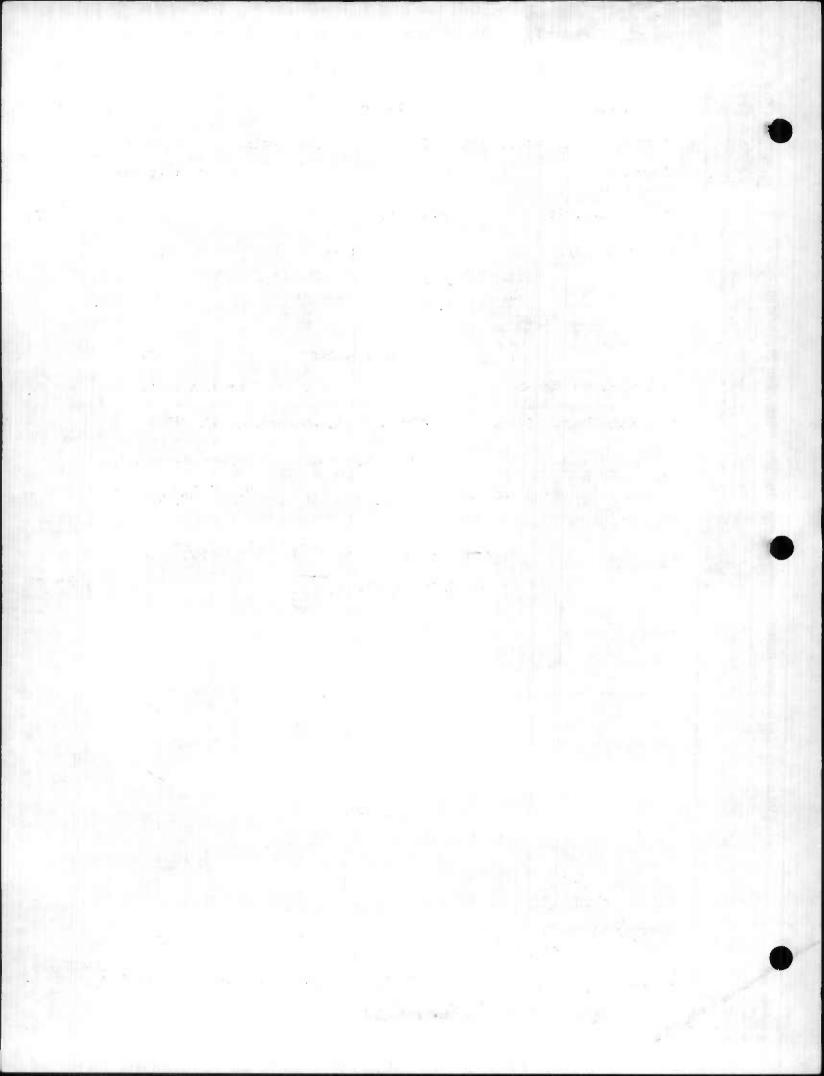
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** John Hamilton Thayer 1998 March 17 8:57pm /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F 219-40-7609 55 Yrs. Director 1942 Md Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "naturel", or items 23s or 28s-f show traumstic event, its Mourcal Examiner mast be incitived at Md Carroll Sykesville 1 Yes 2XXXIO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4419 Klee Court 21784 USA permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If Itam 27 Is marked other than "naturel", or Items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 DYes 2 No 1963− If Yes, Give Year or Detes: 1967 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify white by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) field engineer NCR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Cowen Thaver Hazel Elizabeth Tucker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Thayer 4419 Klee Ct. Sykesville, Md. 21784 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) Important: If it any injury or o 3-21-98 Sykesville, Md. Lake View Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility P.O. Box 195 Sykesville, Md. 21784 Chapel Paige Haight Herbert 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** VENTRICULAR FIBRILLATION Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of):

RD IONY O NATURY

Due to (or es e consequence of): Examiner physicien and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest P.O. Box 68760, Physiclan/Medical Due to (or as e consequence of): the attending 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, g The law requires 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? Completed peeu certificata hes 2/ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3D DOA this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 24 hours after death.

Funeral Director: After it 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital p Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and minimio. □ and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletaly (Check only one) within 2 100 29d. Dete signed (Month, Day, Year) 29c. License number of person who completed cause of deeth (Item 23a) (190e, Print). oudes 31. Date filed (Month, Day, Year)

State Registrar MAR 1



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Salisbury Cente	er. Genesis	ElderCa Age (In yrs. last bii	Thoay) If I	Jnder 1 Y	eer Salie	aphi	Y 8. Date of B	irth Wic	omic	iplace (State or Foreign
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Toe. State Too. County		10c. City, Tow								10d. tnside Clty Limits 1 Yes 2 □ No
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3 Widowed 4 □ Divorced	if Yes, Give Yeer or Detes	•	1 🗆 Y	es 2	No Specify	:		Speci		White
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Arthur W. Todd,								ber, City or Town		
20a. Method of Disposition	01./3011	20b. Place o	f Disposition	/Neme o	of	., [Dete	Anne,		
1 Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (Sp.		(0)	ry, cremetor				0.104.100			nne, MD.
21. Signeture of Funeral Service L 22. Part 1. Enter the disease, or o shock, or heart feiture. List of	complications that cause only one cause on each	ine.	Hinma 1167: not enter the	an Fi 3 Soi	ddress of Fecil Uneral Merset dying, such es	Hom Ave	. Prin	cess Anr arrest,	ne, M	d. 21853 Approximete Intervel Between Onset end Deeth
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resulting in death) Lest									i	
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Pert It. Other significant condition P=6 Tub	2		1	_	e given in Pert	 I.		tobacco use c		to the cause of death?
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25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ tnpat	tient 2 ☐ ER/Ou	utpatient 3[□ DOA	Other		ath <i>(Check only</i> Home 5 ☐ Res	one)	her (Spec	ify)
27. Menner of Death 1. Naturei 5 Pending 2 Accident investigs	28e. Date of fn (Month, D		Time of njury M		injury et Work? 1 ☐ Yes 2 ☐			how injury occu		
3 Suicide 6 Could no determin	ed Zoe. Plece of II	njury - At home, fe etc. (Specify)	rm, street, fa	actory, of	fice		28f. Location City or To	(Street end Num own, Stete)	ber or Ru	ral Route Number,
29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physictan: To the bes xaminer: On the basis and manner s	of examinetion en	o, deeth occu d/or investig	urred et th	ne time, dete er my opinion, dea	nd place ath occu	e, end due to the urred et the time	e cause(s) and m	nenner es , end due	steted. to the ceuse(s)
29b. Signeture end title of cortifier	ong manner s			29c. Li	cense number		_	29d. Date sign	ed (Month	Dey, Year)
· Ch	w			1	2398	31	3	3/1	8/9	28

32. Rolling SHEALTHWAY DR., SALISBURY, MD. 21804

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Year)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burdar-transit completely filled in by the funeral director, page 2 should be detached for use as the burdar-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

MARY OF STANK SEEL OF LEADIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Alice Theil 29 1998 /Medical March 4:00 a.m. 4a. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pleasant Living Conv. Center Edgewater Anne Arundal If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Steta or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 F Yrs. **Director** 167-50-3437 98 Dec. 25 1899 Ohio Usual Rasidance of Decedent with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Oueen Anne's Chester 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 107 Bufflehead Court 21619 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11 Marital Status 14. Race - American Indian. Black, Whita, atc. 12 should be filed within 72 hours after a sand Mental Hygiene.
Is marked other than "netural" or Hear 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify White À 3 NWidowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Self Elamentary/Secondary (0-12) Collaga (1-4or 5+) 8th grade Housewife N/A 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meldan Surnema) Unknown Unknown 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Haalth and Important: If Item 27 Is m any Injury or other traum once. Marie Frances Theil 107 Bufflehead Court Chester, MD 21619 20b. Placa of Disposition (Nema of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 1998 4 ☐ Donation 5 ☐ Othar (Specify) Penn-Lincoln 31 Pennsylvania Mar. 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam 106 Shamrock Rd., Chester, MD 21619

Approximeta Intarval Between Onsat and Degith plications that caused in death. Do not antai Physician More Tha /Medical Immediata Cause (Finel disaasa or condition resulting in death) hermer Examiner YRANS Dua to (or as a consequanca of): Examiner g physician and as the burial-transit Sequantially list conditions, if any, leading to immediata cause. Entar Undarfying Ceuse (Disease or Injury that initiated events rasulting in death) Last Dua to (or as e consequence of): Box 68760 certificata be Physician/Medicai Dua to (or as a consequence of): 980 ō P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be detached 23b. Did tobacco use contributs to the cause of death? the 2 1 Yes 2) No 3 Probably 4 Unknown Records, Š been si 24b. Wara sutopsy findings Completed 24a. Was en sutopsy avellable prior to completion of cause of deeth? performed? page 2 has 1 TYAS 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa rafarred to medical axaminar? Be 28. Place of Deeth (Check only one) Hospitai: Other: Nursing Homa 5 Rasidanca 8 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred of or Attending P safter death.

I Director: After id in by the funer After 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28a. Placa of Injury - At homa, ferm, streat, factory, office bullding, atc. (Specify) 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital of 24 hours at Puneral D 1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifiar (Check only To the P within 2 29b. Signature and titla of certified 29c. Licensa number 29d. Data signed (Month, Dey, Year)

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who completed cause of deeth (item 23a) (Type, Print)

32. Registrar's Signatura

Julia Davidson

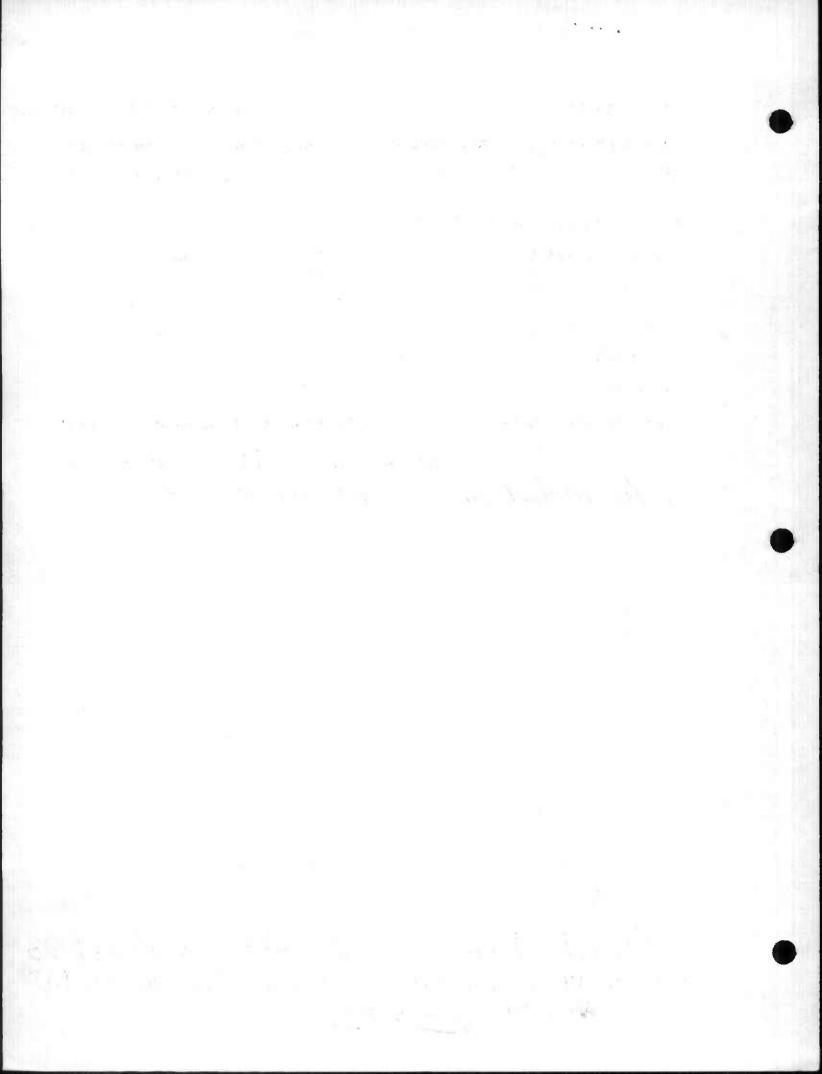
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State Registrar ne end eddress of person

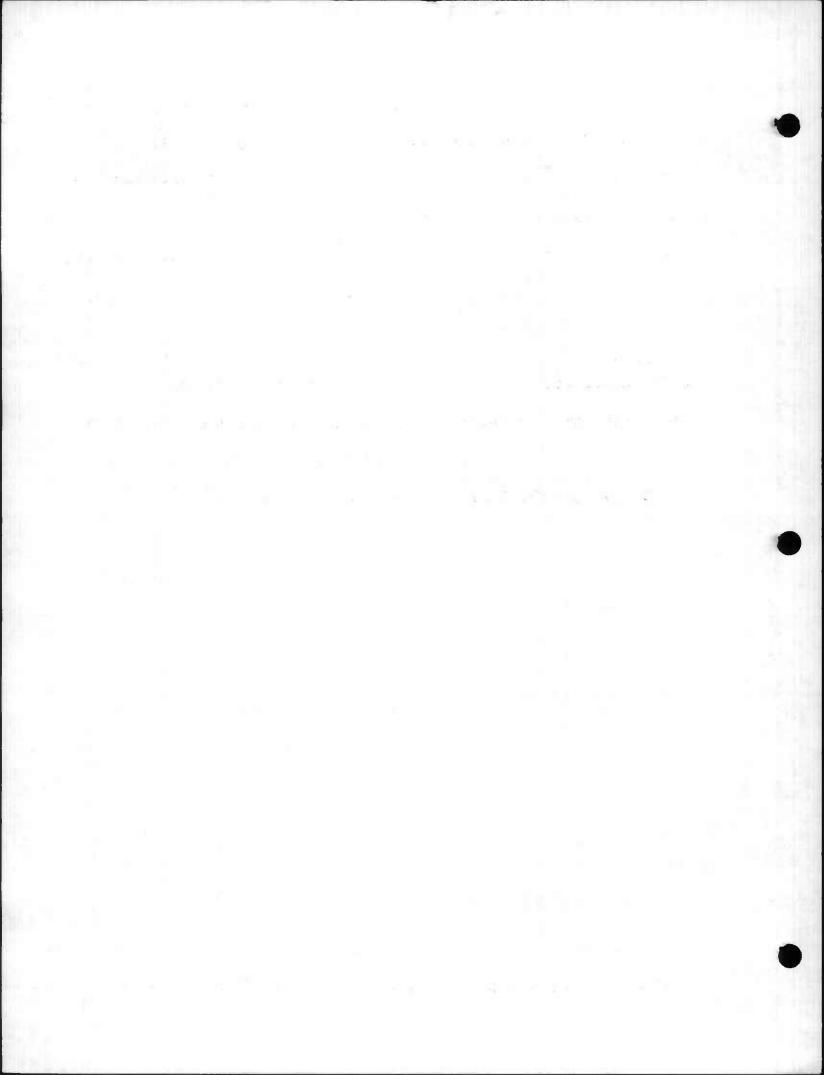
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31. Dete filed (Month, Day,

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٠	Funeral				ga (In yrs. last bi	rthday) If Un	der 1 Year	If Undar 24 Hrs	8. Date of Bir	th		
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115	or Attending effer death. Director: Affer in by the fune	Certification:	3 Suicide 6 Could not to determined	28e. Placa of in building, et	ury - At home, fa	ırm, street, fac	tory, offica	,		Streat and Numi	ber or Rural	Route Number,
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		-	29b. Signature and title of certifier					se number		29d. Date signe		
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			30. Name and addrass of person who	complated cause of c	leath (Item 23a)	(Type, Print)		******			,	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** Virginia Mary Weaver

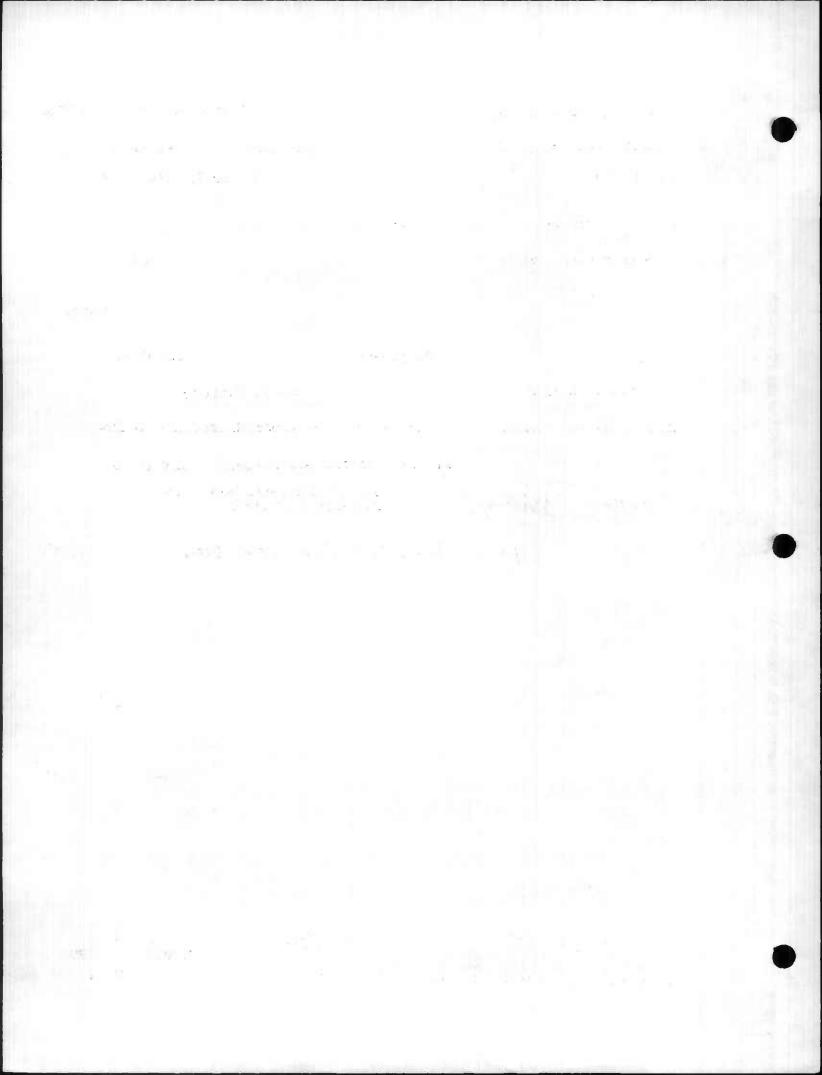
4a Fecility Name (If not institution, give street end number) MARCH 20 1998 0100am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Sacred Heart Hospital Allegany Cumber land Date of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthdey) If Under 1 Yeer Sirthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** Months Days Min 1□M 2₽F Hours Director 197-30-8737 57 Jun 7, 1940 PA Usual Residence of Decedent with the Merylend 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 21502

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18 Pennsylvania Avenue USA 14. Race - American Indian, death permit. Pages 1 and 2 should be filed within 72 hours effer deat Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural". And any injury or other traumatic average. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 🏖 ☐ No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middla, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Charles S. Wilson Mary M. (Keller) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Kenneth Weaver-husband 18 Pennsylvania Avenue Cumberland MD 21502 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial Gardens 03/23 LaVale MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. aneo Cumberland MD 21502

The death. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, 23a. Pa/1. Entar tha disease, or complications that superstock, or heer failure. List only one ceuse on ach Approximete Intervel Between Onsef end Deeth **Physician** DRSTRUCTIVE PURMONARY /Medical Immediata Causa (Final YEBRI disease or condition resulting in death) **Examiner** Dua to (or as a consequence of) Examiner physician end the bunal-transit requires that the deeth certificate be executed Sequantielly list conditions, if any, laeding to immedieta ceuse. Enfer Underlying Cause (Disaase or injury that initiated events resulting in deeth) Last Dua to (or es a consaquance of): Physician/Medical Due to (or as a consequence of) 98 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 | Yes 2 | No 3 Probably 4 Unknown been signed by should be detec Records. þ 24b. Wera autopsy findings evalleble prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes page 2 2 400 1 Yes 2 No 1 Yes certificate Division of Vital Hospital or Attending Physician:
124 hours after death.
 Funeral Director: After this certifica director, 25. Was case referred to medicel 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: 5 Pending investigation 1 Hatural 1 Yes 2 No 2 Accident 6 Could not be datarminad 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

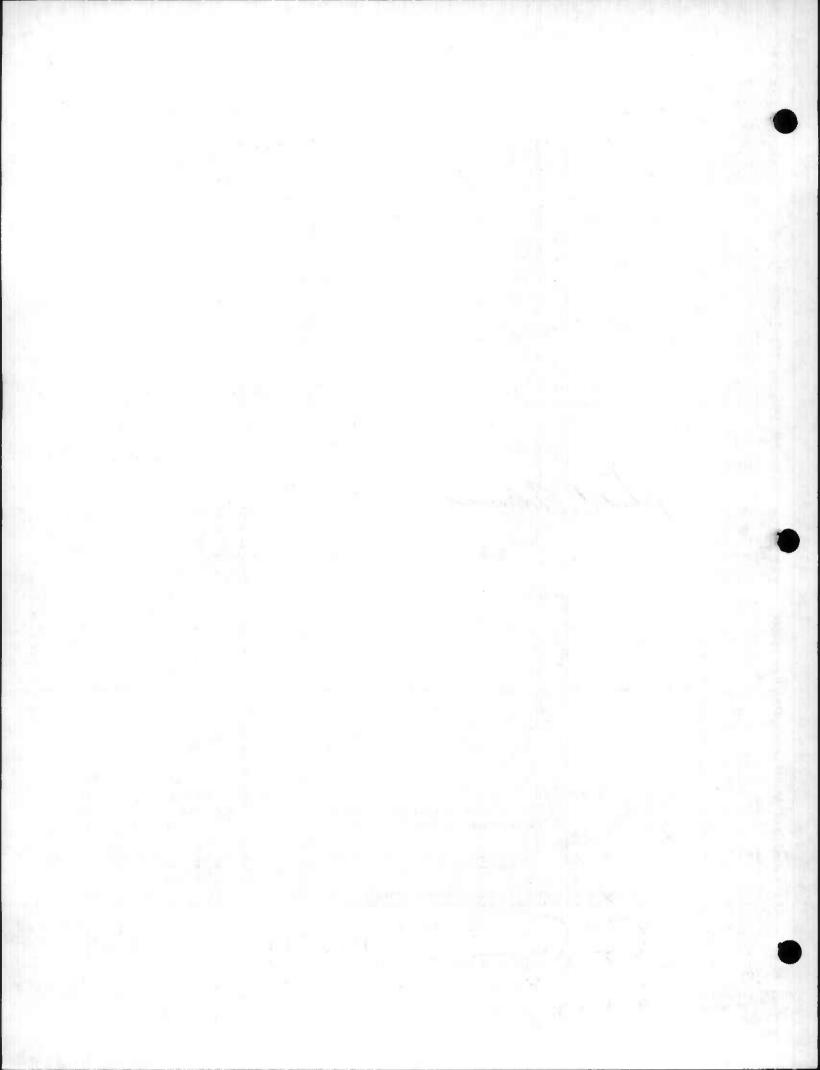
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hospi within 24 hou To the Funer completely fil 29a. Certifian 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature will title of certifier 3 30. Name and address of person who complated cause of daath (Itam 23a) (Type, Print) SETON PRINT amostron my 2650) no 6. MAGBO JOS 1998 (ear) Jaha Asselps state Signature

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		leg. No.	1 U	481
Physi	ciar	1. Decedent's Neme (First, Middle, Last)	2. Dete of Dee Month	th Dey	Yeer 3	. Time of Deeth
/Med		CHADIEC EDGAD	MARCH	-		5:00 AM
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1110		13504 Poppy Street Cumber1	and	A 1 1	00000	
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hi	rs. 8. Dete of Birth	1	egany	(State or Foreign
Directo		218-30-0575 15xM 2□F 61 Yrs. Months Deys Hours Min	n. (Month, Dey Oct. 23	, Yeer)	-	(Stete or Foreign
and **		10e. State 10b. County 10c. City, Town or Location			104	Inside City Limits
Aary	1 2	Maryland Allegany Cumberland				1,□Yes 2□No
the h	Director	10e. Street end Number				****
A P	اخ	106. Street end Number 10f. Zip Code	1	log. Citizen of W	/hat Country?	
eth 234	Finaral	13504 Poppy Street 21502		USA		
eb Te	901	11. Maritel Stetus 12. Wes Decedent Ever in U,S. 13. Was Decedent of Hispenic Origin? (Armed Forces? If Yes, specify Cuben, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)		- American I k, White, etc.	ndlen,
Maryland 21215-0020 d 2 should be filed within 72 hours efter deeth with the Maryland th and Mantal Hygiene. 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examinet must be notified.	2	3 Widowed 4 Divorced Year or Detect 954-62 1 Yes 2 No Specify:		Specify:		e
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re, Marylis 1 and 2 should 1 multh and Men 1 multh zris marke	-	19a. Informent's Neme/Reletionship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street end Number or F</i>	ATHRYN MI			de)
and 2.		Shirley Ann Widdows Wife 13504 Poppy Street, C				
0 - F E E		20e. Method of Disposition 20b. Pleca of Disposition (Neme of	Dete	20c Location - (City or Town	State
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Saltimore, Department of Heal Important: If Item 2	8	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Merritt-Adams Fune	ral Uomo	D A		
- 00240		Your Street	Cumber1	and MD	2150	2
		23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinal shock, or heart fellure. List only one cause on each line.	ec or respiretory err	est,	App	proximete erval Between
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/Medica	_	Immediate Cause (Final disease or condition co	nne		21	ang.
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d for	icia	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.	23h Did to	hacco uso con	telbute to the	cause of death?
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Attending Physician: r death. ector: After this certific by the funeral director.	cat	2 Accident Investigation 3 Suicide 6 Could not be 329 Place of latter. At home form short feature files				
lor Attending effer death. Director: After din by the fune	Certification:	4 ☐ Homicide determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town		r or Rurel Ro	ute Number,
is is is						
To the Hospital or Attending Phy within 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral	edical	29e. Certifier (Check only Medical Examiner: On the best of my knowledge, deeth occurred et the time, dete end pled (Check only Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occ	ea, end due to the co curred et the time, d	euse(s) end men ete end place, a	ner es steted	cause(s)
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5 ¥ 5 00	-	29b. Signeture end tittle of certifier 29c. License number	2	9d. Dete signed	(Month, Day,	Year)
/		Uldily		212	5 19 X)
Yras		30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)			1	
100		Dr. Guy Fiscus 500 Memorial Avenue Cumberland, N	D 21502			
	ate	31. Dete filed (Month, Dey, Year) MAR 2 3 1998				
Regist	rar	MIAD A A MAK				



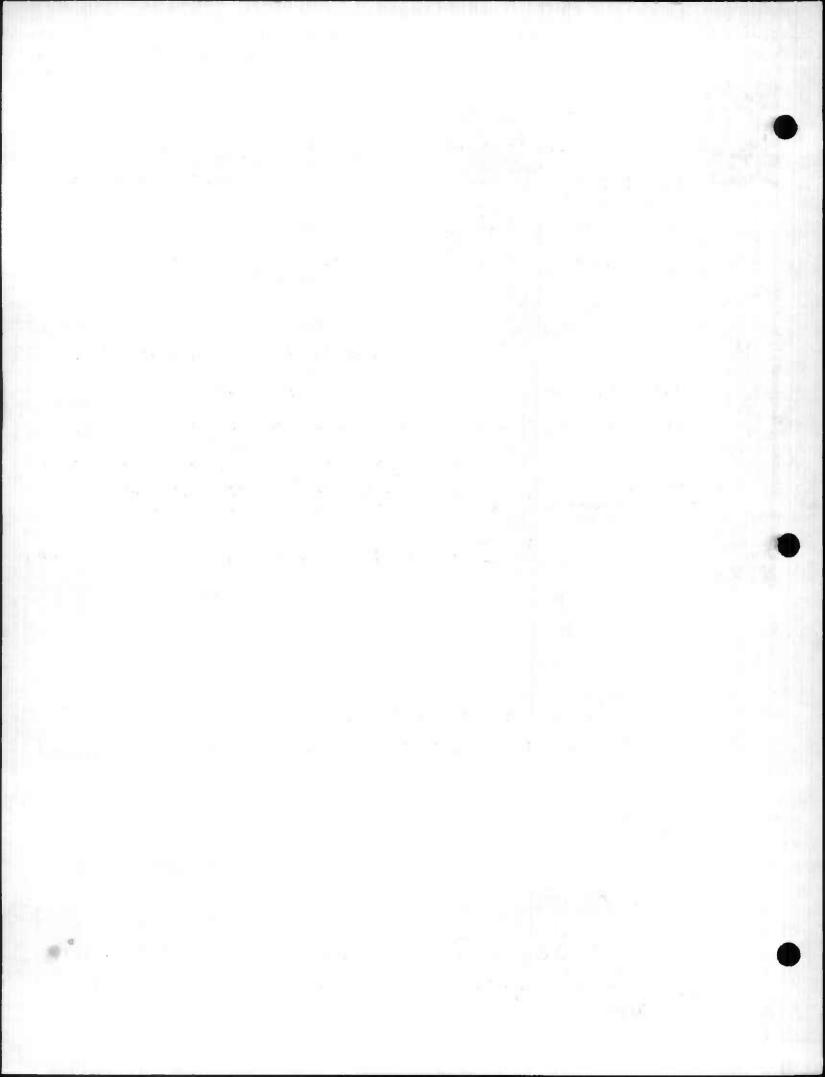
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yaar **Physician** HILDA MAE WILLIAMS MARCH 1998 6:00 PM 16 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner MORAN MANOR NURSING HOME WESTERNPORT
If Under 24 Hrs. 8, Dete If Under 1 Year 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Months Days Hours Min. Yrs. Director 214-07-6774 82 JUNE 3,1915 MARYLAND Usual Residence of Decedent the Maryland 10e. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rithen "natural", or items 23s or 25s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND LA VALE ALLEGANY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 1251 BRADDOCK ROAD Funeral 21502 12. Was Decedent Ever In U,S. Armed Forcas?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - Amarican Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: if Item 27 Is merked other than "natural", or fler any injury or other traumatic event, the Medical Examinations. Bleck, White, etc. 1☑ Never Married 2☐ Married Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MAIL ROOM WORKER FIBER/TEXTILE 12 17. Fether's Name (First, Middla, Lest) 18. Mother's Neme (First, Middle, Meiden Sumema) JOSEPH WILLIAMS BESSIE (GORDON) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) VIOLA HILLEARY/FRIEND 1251 BRADDOCK ROAD, LA VALE, MD 21502 20b. Plece of Disposition (Name of cametery, cremetory or other piece) 20a. Method of Disposition MARCH 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) HILLCREST BURIAL PARK 19,1998 CUMBERLAND, MD 21. Signatura of Funeral Service Licensee 22. Nama and Address of Fecility HAFER CHAPEL OF THE HILLS MORTUARY 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest,

Approxime Interval Belline. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Intractable Congestive Heart Failure 2 months disaasa or condition resulting in daath) **Examiner** physician and s the burief-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceusa. Entar Underlying Ceuse (Disease or Injury that initiated events rasulting in deeth) Lest Due to (or es e consequança of): Box 68760 Physician/Medical Due to (or es e consequence of) attending for use es P.O. Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 □ Probably 4 ☑ Unknown Records, þ 24b. Wara eutopsy findings available prior to Cresmpting metastatic Caranoms Completed 24a. Was an autopsy peed completion of ceuse of death? page 2 1 Yas 2000 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I Be 25. Was casa referred to medicel 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Daath 28a. Data of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 4 ☐ Homicida 1 Sertifying Physician: To the best of my knowladge, death occurred et tha tima, data and place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, daeth occurred et tha tima, data and place, and dua to tha ceusa(s) and mannar stated. Medical 29a. Cartifier (Check only 29b. Signetura and titla of certifier 29c. Licanse number 29d. Dete signed (Month, Dev. Year) MARCH 17,1998 D 21244 6 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) FROSTBURG PLAZA FROSTBURG, MD H. TAN Jesus 2. Fundanter's Signature 31. Dete filed (Month, Day, Year)
MAR 1 8 1998 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Day 5:19 am SYLVESTER FRANCIS WALKER 18, 1998 March /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Allegany Memorial Hospital & Medical Center Cumberland 6. Sex 1 M 2 □ F If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) JAN 19 1923 5. Social Security Number 7. Age (In yrs. lest birthday) **Funerai** 9. Birthplace (State or Foreign Months Days Hours Min MARYLAND 215-16-4722 75 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or itama 23a or 28a-f ehow The Medical Examinar must be notified at 10d. Inside City Limits Director XXYes 2 No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 512 PINE AVENUE 21502 U.S.A. Funeral Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Marital Status 14. Race - American Indian. Black, Whita, etc. hours efter 1 ☐ Navar Married 2 ☐ Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: WHITE þ 3 ☐ Widowed 4 🏋 Divorced Year or Dates: WW11 Pop 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 72 Complet Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 8 WESTERN MARYLAND RAILROAD BRAKEMAN/Railroad marked other 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Be 2 should be fi end Mental F Is marked of JAMES A. WALKER HELENA MAE MILLER 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Depertment of Health end Important: If Ikem 27 is m any injury or other traum 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) VIRGINIA JAMES DAUGHTER 509 PINE AVE CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Neme of cemetary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Removal from State ROCKY GAP VET CEMETERY MARCH 20 1998 FLINTSTONE MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Sign ature of Funeral Service, 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME erull 404 DECATUR STREET CUMBERLAND MARYLAND X 23a. Part1. Enter the disease, or com shock, or heart failura. List only plications that caused the death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest on a cause on each line. Approximate Interval Between Onsef and Death **Physician** /Medical Immediata Causa (Final disaase or condition resulting in death) Pneumonia One Day Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last -tren pue Dua to (or as a consequence of): ettending physicien effor use es the burial-Box 68760 Physician/Medical Due to (or as a consequence of) 98 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. detached 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown Records. þ been sig Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of daath? cate hes l 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner'i Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of July - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 4 Homicide 1 Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and prenner stated.

nds

31. Date filed (Month, Day, State 1998 Registrar

29b. Signature and title of or



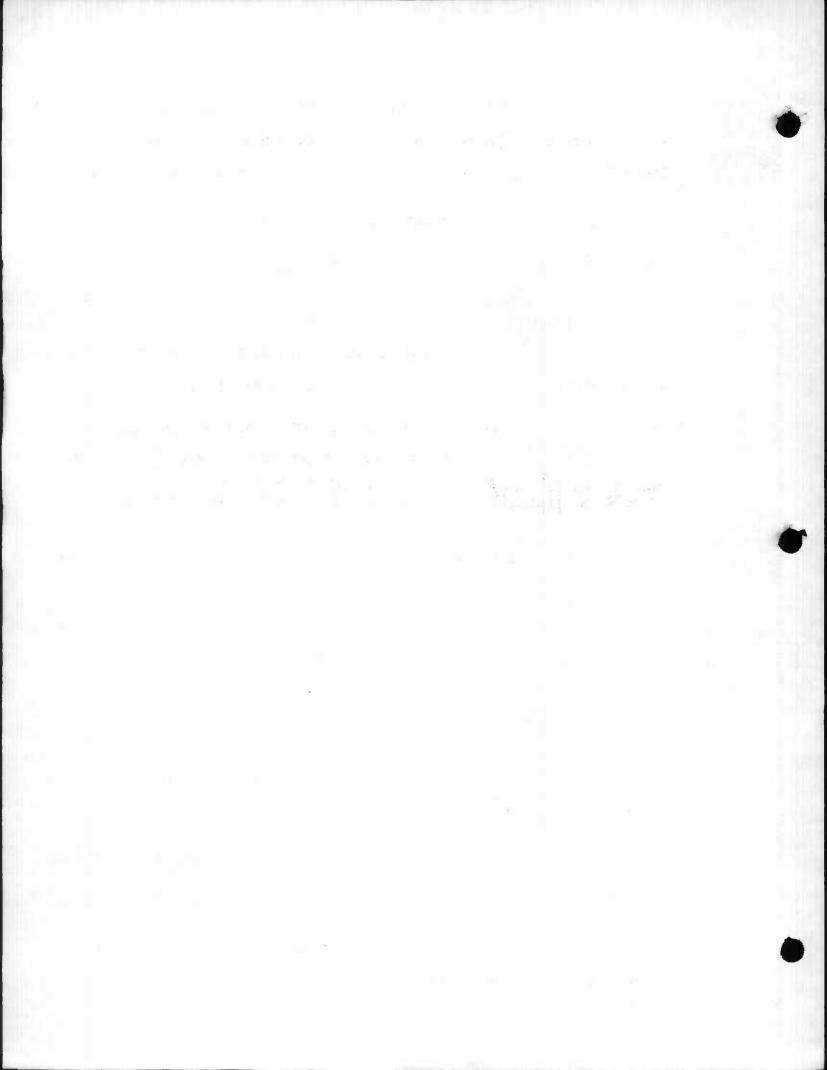
30. Nama end addrass of parson who complated causa of death (Itam 23a) (Type, Print)

29c. Licansa number

D 36766

21502

29d. Date signed (Month, Dey, Yeer) March 18, 1998

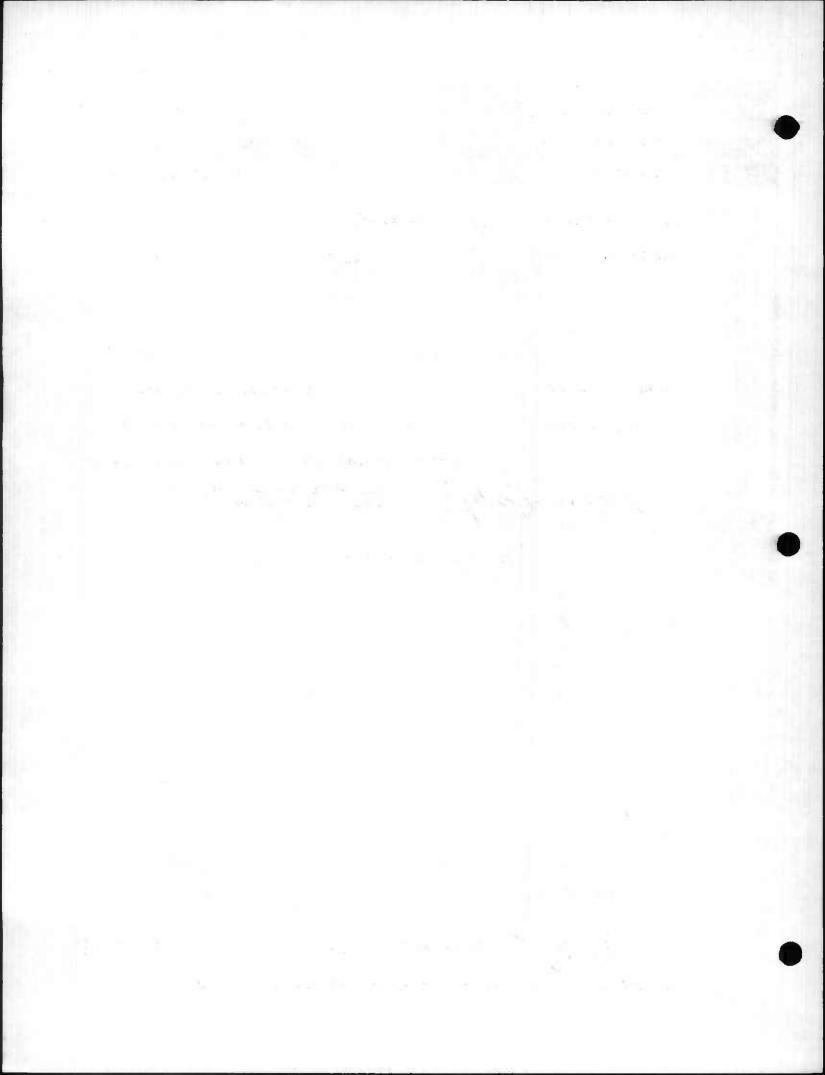


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Yee Mar 6, 1998 Larry Ernest Wigfield 12:00 am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth. 4c. County of Deeth Examiner Sacred Heart Hospital Allegany Cumberland 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) Dete of Birth **Funeral X**□ M 2□ F Deys Yrs. Director 219-44-1070 51 Usual Residence of Decaden with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f shor traumatic event, the Medical Exampler must be notified at 1 ☐ Yes 2€ No Director Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 812 Shawnee Avenue 21502 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or ther any injury or other traumatic event, the Medical Examina 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 Widowed 4 Divorced white Completed 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Schwab's Co. Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Ernest Wigfield Geraldine I. (Shoemaker) 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Gail Wigfield-wife 812 Shawnee Avenue Cumberland MD 21502 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 03/09 Cumberland MD 21 Signature of Augustal Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. Cumberland MD 21502 that the disease, or complications that caused the heart fallure. List only one cause on each inc. Do not enter the mode of dylng, such as cardiac or respiratory errest, Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) 6 Mos. Metastatic Lung Cancer Examiner Due to (or es a consequence of) siclan and burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physiclan s the burial Box 68760 Physician/Medical Due to (or es e consequence of): attending ō signed by the at d be detached for P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? should 24a. Wes en eutopsy performed? Completed certificate 1 ☐ Yes 2 X No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 N Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 X Neture 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide edical 🛣 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es stated. 29a. Certifier 2 Madical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of contribution 29c. License number 29d. Date signed (Month, Dey, Year) PHYSTECAN D 50844 completed cause of deeth (Item 23e) (Type, Print) Loveria Jr., MD 912 Seton Drive Cumberland MD 21502 22. Figistrat's Signature State Registrar

DHMH 16 Rev 6/95



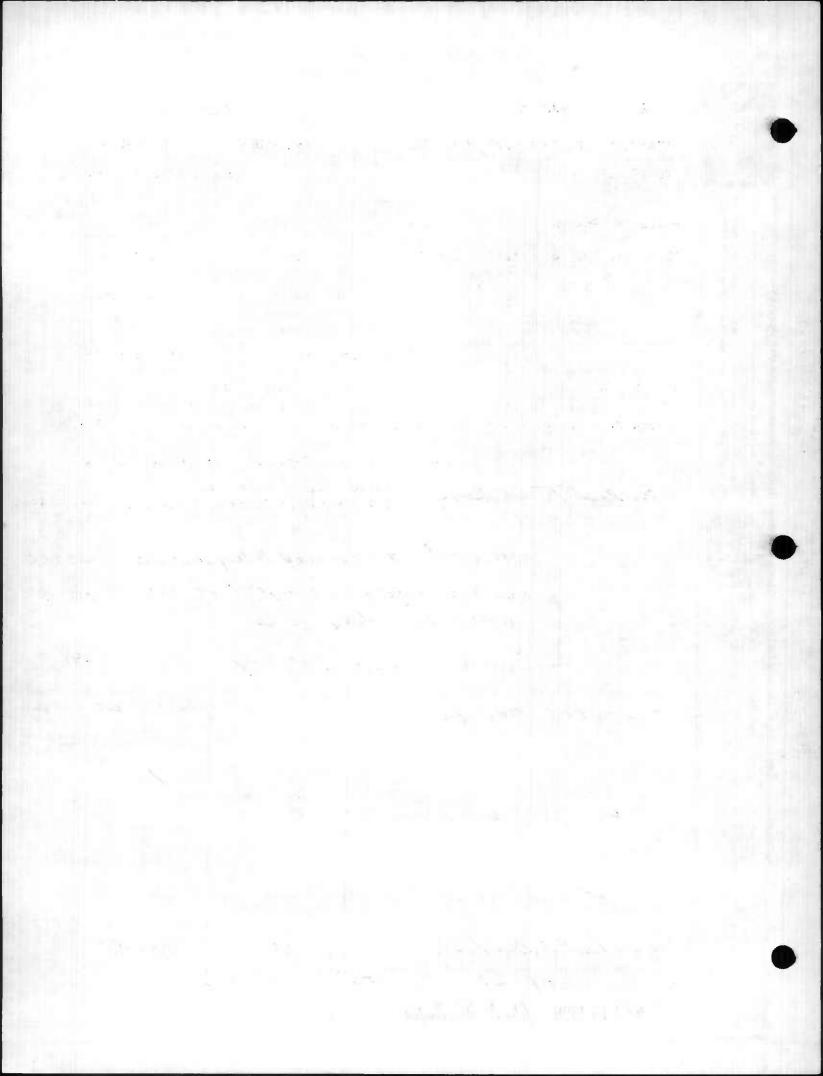
State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1137 **EDWARD** WAHOWSKI march 14 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO SALISDUAL
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) 6. Sex 1 M 2 □ F If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Yrs. 196-18-7563 70 MAY 4, 1927 **Director** Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits the Marvie 1 ☐ Yes 2X No Delaware Sussex Millsboro 10g. Citizen of What Country? 10a, Street and Number 101. Zip Code Long than "naturel", or items 23s or the Medical Examiner must be 150 River RD, Pot-Nets Bayside, Neck 19966 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Yeer or Dates: 14. Race - American Indien. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Naval Engineer Ship Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) should be fund Mental H Joseph Wahowski Rose Samsel 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 siment of Health en Edward M. Wahowski / Son 10111 Old Towne Lane, Sugar Land, Texas 77478 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buriel 2 Cremation 3 Removal from State Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory Services 3/16 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Watson Funeral Home, Inc. Water 211 Washington Street, Millsboro, Delaware 1996 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** /Medical arterioselerotic Coronary Artery disease Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** b. Heart damage and congestive Heart Examiner physicien end the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Failur secondary to Q. Physician/Medical Due to (or as a consequence of) that initiated events resulting in death) Last pass surgery esn Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Diebetes 1 Yes 2 No 3 Probably 4 Unknown mellitus 24b. Were autopsy tindings evailable prior to completion of ceuse of death? 24a. Was en eutopsy performed? certificate has t irector, pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Ampatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c, Injury at Work? 1 ANatural 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be n 24 hours after dea ne Funeral Director nietaly filled in by th 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Grichart & Buchen D02038 30. Name and address of person who completed couse of death (Item 23a) (Type, Print) Michael P, Buchness, M.D. 201 Pine Bluff Rd- Salisbury Md. 2/10/ 10 31. Date filed (Month, Dey, Year)

32. Registrar's Signature

DHMH 16 Rav 6/95

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Q

			Certifica	te of Death		Reg. No.	10486
Dhynia		Decedent's Neme (First, Middle, Last)			2. Dete of Dee		3. Time of Deeth
Physic /Med		MARIE WASHINGTON			03	15 1998	
Exami		4e. Facility Name (If not institution, give street end number)		4b. City, Tow	n, or Location of Deeth	4c. County of De	
		SALISBURY CENTER GENESIS EL	1 1011	SALISB r 1 Year If Undar 2		WICOMIC	
Funeral Director		5. Sociel Security Number 20-03-5024 Usuel Residence of Decedent	n yrs. last birthday) If Under Months 8 3 Yrs.		Min. 8. Deta of Birth (Month, Dey	y, Year) 9. E	lirthplaca (State or Foreign Country) MD
ylend		10e. Stete 10b. Coupty	Oc. City Town or Location	1			10d. tnside City Limits
Sa-f s	ctor	MD Somerset	Princess	Anne			1 ☐ Yes 2 🕱 No
Z1Z15-0UZ0 d within 72 hours after death with the Marylend sjene. r than "natural", or items 23a or 28a-f show the Medical Examiner mast be ricitled at	Funeral Director	13200 Five house RD	10f. Zi _l	21853		10g. Citizen of Whet	Country?
ar de	nue	11. Maritei Stetus 12. Was Decedent Eve Armed Forces?	r in U,S. 13. Was Dece If Yes, spe	dent of Hispenic Original Cuban, Mexicen,	in? (Specify Yes or No- Puerto Ricen, etc.)	14. Race - Ar Bleck, Wi	nerican Indian, hite, etc.
Z I Z I 3~00Z0 d within 72 hours aft gjene. yr the "natural", or in	by	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Yeer or Datas:	1 □ Yes			Specify: L	Black
n 72 in met	Completed	15. Decedent's Educetion (Spacify only highest grade completed)	16e. Decedent's Usu (Give kind of wo life. DO NOTu	ork done during most of	of working	16b. Kind of Busines	ss/Industry
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	Bec	17. Fathar's Name (First, Middla, Last)		18. Mothar	s Name (First, Middle	Maiden Sumame)	
0 4 4 0	To	Thomas Smith		COR	inclia di	Dence	
te, Ind your your your theath and Mer theath and Mer them 27 is marke other traumatic		19e. tnformant's Name/Relationship (Type, Print)			or Rurel Route Number	, ,	, Zip Code)
		LOVIE DAShicll Sister 20e. Method of Disposition	404 EAST 20b. Piece of Disposition (Ne			-Alisbury,	MD 21807
8 5 = 9		1 Bunai 2 □ Cremetion 3 □ Removel from Stata	cometery, cremetory or o	other place)	3-21-98	20c. Location - City	
permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funeral Service Licensee	A	c July nd Address of Fecility	3-21-70	141. VEY	non, MD
permit. Departm Importar any Inju		Antlyn E. War	30639	Hampden	Ave. Prince	SS Anno.	MD 21953
		23a. Part 1. Enter the disease on complications that caused the shock, or heart feilure. Lut only one cause on each line.	death. Do not enter the mod	de of dying, such es c	erdiac or respiretory err	est,	Approximete intervel Between
Physician /Medical		Immediate Ceuse (Finel	10.	100	00	0.0	Onset end Death
Examiner		disease or condition resulting in deeth)	MONE	1 leave	Mil	lene	prioco
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rificate be executed g physician and es the burial-trensit	Examiner	Sequentially list conditions,	e to (or es e consequence of):	75.0.0	770		
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he law requires that the has been signed by the age 2 should be detacht	Completed			<u> </u>	24e. Wes e perfor		o. Were eutopsy findings evallable prior to completion of cause of deeth?
The law ate has page 2:	Com				1 □ Y	es 20 No	1 ☐ Yes 2 ☐ No
sician: The certificate lirector, pa	Be (25. Wes case referred to madical exeminer?		28. Place of	of Deeth (Check only or	16)	
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or Attending effector: After Director: After	Certification:	2 Accident investigation 3 Sulcide 6 Could not be	At home form street fector	1 Yes 2 N		treet and Number or	Rural Route Number,
or A Oliver Jin by	ertil	4 Homicide determined 206. Piece of injury building, etc. (S	 At home, ferm, street, fector Specify) 	y, onice	City or Tow		narai noute ramber,
To the Hospital or Attending Physician: The Is within 24 hours efter deeth. To the Funeral Director: After this certificate ha complataly filled in by the funeral director, page	edical C	29e. Certifier (Check only one) 1 Certifying Phyeiclan: To the best of m	aminetion end/or investigetion	et the time, dete end , in my opinion, deeth	plece, end due to the coccurred at the time, d	euse(s) end menner lete end plece, end d	es steted. ue to the ceuse(s)
vithin To the	Me	29b. Signeture and title of certifier		c. License number	ce. I	29d. Data signes (Mo	nth, Dey, Year)
- 5 - 0		V/1 6 to		1015	7013	3/16	188
		30. Name end eddress of person who completed cause of death	(Item 23e) (Type, Print)	0 1)	700	8 - 0- 0
		MATKUS MW	2 1104	Kesell	way /	Lowe	STES My
	ate	31. Dete tiled (Month, Day, Year) 32. Registrer's	Signeture Revolution			718	2000
Regist	rar	MAR 2 0 1998 Julia	IN KIND OF THE PROPERTY.			2-6	

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State of Maryland / Department of Health and Mental Hygiene

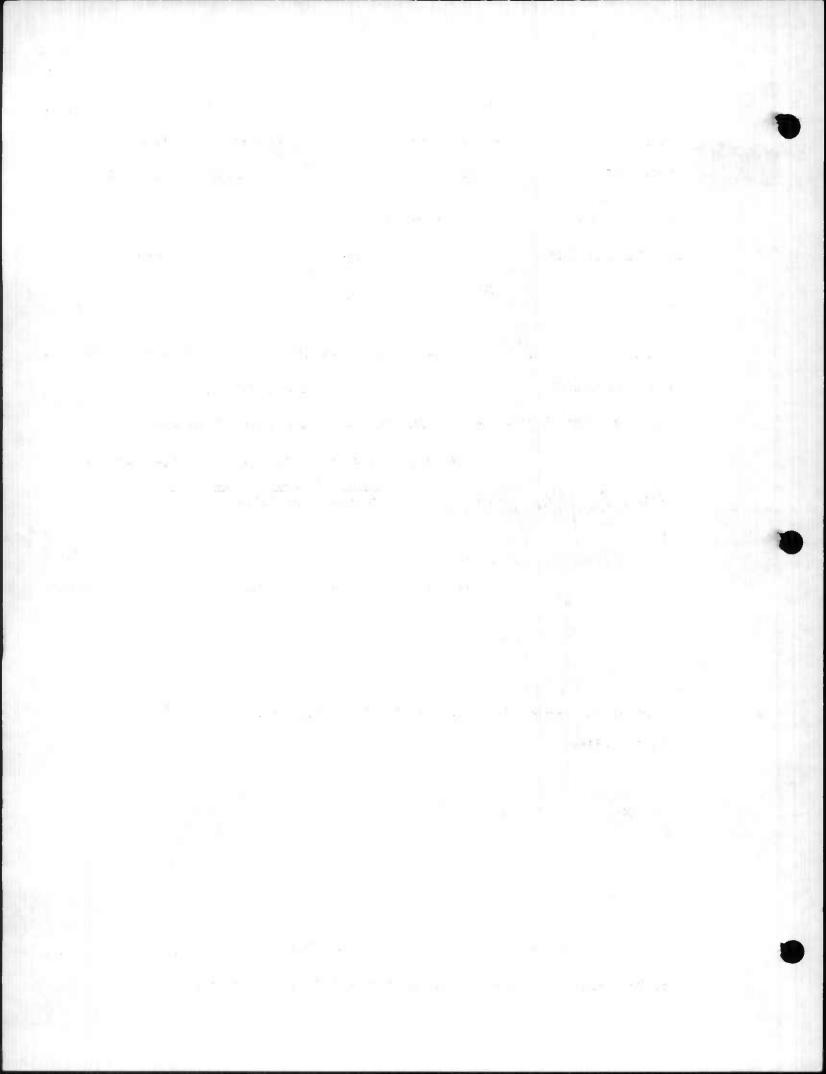
Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death **Physician** Month Dev Yeer MARY ZIMMERMAN 9,1998 5:14 pm March /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Memorial Hospital & Medical Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1□M 210F Months Yrs 84 Director Sep 24, 215-36-8875 WV Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Nes 2□No Director Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 517 Caroline Street **Нета** 23a 21520 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours aftar and Mental Hygiane. marked other than "natural", or ite 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. by 35 Widowed 4 □ Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elamantary/Secondary (0-12) Coltege (1-4or 5+) Ret. Social Worker 12 MD Social Services 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meidan Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked of James R. Nutter France (Wolfe) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau Margaret Boettcher-sister-in-law 2915 Gordon Street Hopewell VA 23868 20e. Method of Disposition 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Davis Memorial Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 03/12 Cumberland MD 22. Neme end Address of Fecility
Scarpelli Funeral Home, P.A. 21. Signeture of Funaral Service Licensis Cumberland MD 21502 ath. Do not enter the mode of dying, such as cerdiec or respiretory errast, Approximate Intarval Batween Onset and Deeth **Physician** /Medical Immadiata Cause (Finel diseese or condition resulting in deeth) Bilateral Pneumonia 23 Days Examiner Due to (or es a consequance of): Examiner Adult Respiratory Distress Syndrome 18 Days The law requires that the death certificate be assocuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated evants resulting in deeth) Lest physician and s the burial-tran Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequenca of): 88 P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure, Valvular Heart Disease, Records, þ 24b. Wara autopsy findings aveileble prior to Completed 24a. Was en eutopsy performed? Renal Failure. completion of cause of daeth? paga 2 s 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Attant his certifica completely filled in by the funeral director, a Be 25. Wes cese raferred to medical 26. Piece of Deeth (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To of 27. Mennar of Deeth 28e. Deta of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Panding Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Spacify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida edical 1) Certifying Physicien: To the bast of my knowledge, death occurred et the time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) end menner stated. 29e. Certifian 29b. Signature end title of certifier 29c. License number 29d. Deta signed (Month, Day, Year) Hma Shalul MO D 46346 1998 March 30. Nama and addrass of person who completed causa of death (Itam 23e) (Typa, Print) me Dr. Huma Shakil-Johnson Heights Medical Building-Cumberland, MD 21502 82. Repistraris Signature State

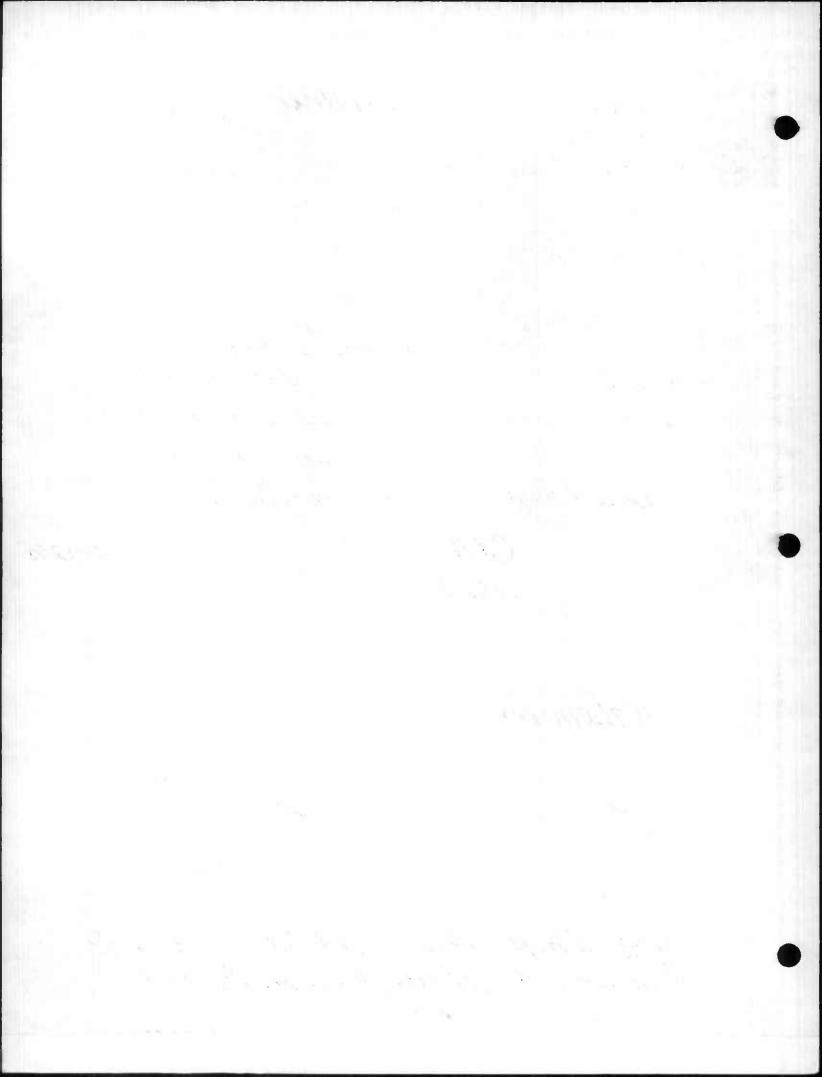
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Le			Certificate of	Death	2. Dete of De	Reg. No.	3. Time of Deeth
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Funeral Director			Sex 1□M 2∏(F	yrs. lest birti 89 Y	hday) If Under 1 Year Months Deys		8. Dete of Bi (Month, Do	9. B ey, Yeer) 25 1908 NY	irthplece (State or Foreign Country)
wo m		Usuel Residence of Decadent 10a. State 10b. County		c. City, Town					10d. Inside City Limits
Mary a-f sh	tor	Md Carroll	V	lestmi	nster				1 ☐ Yes 2 ☐ No
th with the 23a or 28	Funeral Director	10e. Street end Number 4158 Salem Botton	n Road		10f. Zip Code 21157			10g. Citizen of Whet (USA	Country?
a within 72 hours efter deeth with the Marylend jiene. r then "netural", or flems 23a or 28a-f show	by	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	in U,S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	en, Mexican, Puert	pecify Yes or No Rican, etc.)	o- 14. Reca - An Bleck, Wh Specify: Wh	
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nd 2 silth ar 27 is r trau		19e. Informent's Name/Refationship (Nancy Urban (dau	Type, Print) aghter)		Meiling Address (Street 58 Salem Bo				
		20e. Method of Disposition 15 Burial 2 Cremetion 3 C 4 Donetion 5 Other (Special	Removel from Stete	cameter)	Disposition (Neme of y, cremetory or other ple y Valley Ga		Dete 3-20-98	20c. Location - City of Towson, Mo	
permit. Pages Department of Important: If it any Injury or once.		21. Signeture of Funeral Service Licer	Aug (4m		P.O. Box 1	Ha		uneral Home Md. 21784	e & Chapel
		23a. Pert1. Enter the disease, or com shock, or heert fellure. List only	plicetiers that caused the one ceuse on each line.	deeth. Do n					Approximate intervel Between
Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	· CVA	2	- G				3-12-9
	Je.		ACI	to (or es e c	onsequenca ot):				
icete be executed physician and s the buriel-transit	Examiner	Sequentially list conditions,	b. // OV /	to (or es e c	on sequence of):				
icete be executed physician and s the burlel-transit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	C						
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Physician: this certific ral director,	o Be	25. Was case referred to medical exeminer? 1 Yes 2 No	Hospitel:	2 ER/Out	petient 3 DOA Oth	26. Plece of Dee		one) Idenca 6 □Other (Sp	neciful
Ifing After fune	ation: T	27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigatio	28e. Date of Injury (Month, Day Yea	28b. Ti	ime of 28c. Inju			how injury occurred	месту
7550	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Pleca of Injury - building, etc. (Sp	At home, far	m, street, factory, office			(Street and Number or I wn, Stete)	Rural Route Number,
To the Hospital or within 24 hours effer To the Funeral Dir. completely filled in	edical (29a. Certifier 1 Certifying Phone 1 Medical Example 1	yelclen: To the best of my niner: On the basis of exer end menner steted.	knowledge, minetion end	deeth occurred et the ti /or investigation, in my o	me, dete end plece opinion, deeth occur	end due to the red et the time,	ceuse(s) end menner , date end placa, end d	as steted. ue to the ceuse(s)
To the To the To the Complex C	W	296. Signeture and title of certifier	off 1	w	29c Licens	FZ78		29d. Dete signed (Mon	nth, Day, Year)
		Neme end eddress of person who Clant to The File	completed cause of death	(Item 23e) (T	P. West	nuster	MD.	2157	
Sta Registr		31. Dete filed (Month, Dey, Year) MAR 1 9	998 32. Registrer's S	Signeture	and II	-			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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- 1			2.1	- mil

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7	Physic //Med Exam	lical	1. De H 4a F
	Funera		5. So 2 Usua 10a.
	Directo	r	11000
	pus *		10a.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permitment of Health and Mental Hygiene. The contract of Health and Mental Hygiene. The contract is them 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ctor	
	r 28	<u>ē</u>	10e.
	23a c	raio	10e. 11. N 1 3
	ep .	ne	11. N
0	or h	F	1
0	alf,	b	3
5-0	72 ho	eted	
Baltimore, Maryland 21215-0020	namit. Pages 1 and 2 should be filed within 7 spartment of Health and Mental Hygiene. Troctant: If Item 27 is marked other than "numerical than "numerical than "numerical than "numerical than "numerical than "numerical than "numerical than "sea".	To Be Completed by Funeral Director	Ele
P	other vent,	Se C	17. F
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Bal	adell and and and and and and and and and and		21.5

	ma (First, Middla, I Edward A			III					2. Date of De Month MARCH	Day	Year 1998	3. Time of Death 2:15 PM
	(If not institution, g		mber)				4b. City. To	own, or L	ocation of Death		County of Death	
Tel Hilland Agen	STON GENE						FALL				ARFORD	
5. Social Security 214-82-	-	.Sex 1∆M 2□F	7. Age (In yi	s. last birthda Yrs.	Months			24 Hrs. Min.	8. Date of Bird (Month, Da May 4,	th y, Year) 1961		hplaca (State or Foreigr untry) 11and
Usual Residence					,							
10a. State	10b. County		10c.	City, Town or	Location							10d. Inside City Limits
MD	Anne A	rundel	GI	en Bur	nie							1 ☐ Yas 2X No
10e. Street and N	lumber By Hill L	320			10f. Zip	061				10g. Chi	zen of What Co	untry?
11. Marital Status 1 Navar Ma 3 Widowed	arried X Marriad	12. Was Dec	2 X No	U,S. 13	. Was Dece	dent of l	an, Mexica	n, Puerto	pecify Yes or No Rican, atc.)		14. Race - Amai Black, White Specify: Whi	a, etc.
(Sp	15. Decedent's ecity only highest of			(Gi	edent's Usu	ork done	during mos	st of work	king	16b. Ki	nd of Business/I	Industry
Elementary/Se	condary (0-12)	College (1-4or 5+)		om Bu					Cabi	net Mak	rer
	e (First, Middle, La Stoddar	•	1				18. Moth		e (First, Middle, Elizabet			
	Name/Relationship E. Gille		other						nnapoli			
20a. Method of D		☐Removal from	20b	. Place of Dis	position (Na	me of other pla			Date 04/02	20c. Lo	cation - City or	Town, State

22. Nama and Addrass of Facility

Physician /Medical Examiner

USB

page 2 s

After this

after deat Director:

24 hours e

funeral

filled in by

completely To the To the To the F

by

Completed

Be

20

Certification:

edical

Division of Vital Records, P.O. Box 68760,

Hospital or Attanding Physician:

Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaase or Injury that Initiated avants resulting in death) Last

Immediate Cause (Final disease or condition resulting in daath)

4 ☐ Donation 5 ☐ Other (Specify)

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

(or as a consequence)

Due to (or as a consequence of)

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No

Baltimore, MD

24a. Was an autopsy performed?

12 Ridgely Avenue, Annapolis, MD 21401

Hardesty Funeral Home, P.A.

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1 Yes 28. Place of Death (Check only ona)

2 No

25. Was casa examiner		to	medica
XX Yes	2 No		
27. Mannar of			

1 Inpatiant Date of Injury 5 Pending Investigation

2€ ER/Outpatient 3□ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yas

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 1 holivoch chim

par of Aural Route Number Roch State Park in Haw ford Comby

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Machine Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certified

29c. License number

29d. Data signed (Month, Day, Year)

0 30. Name and address of person who complated cause if death (Item 23a) (Type, Print)

6 Could not be determined

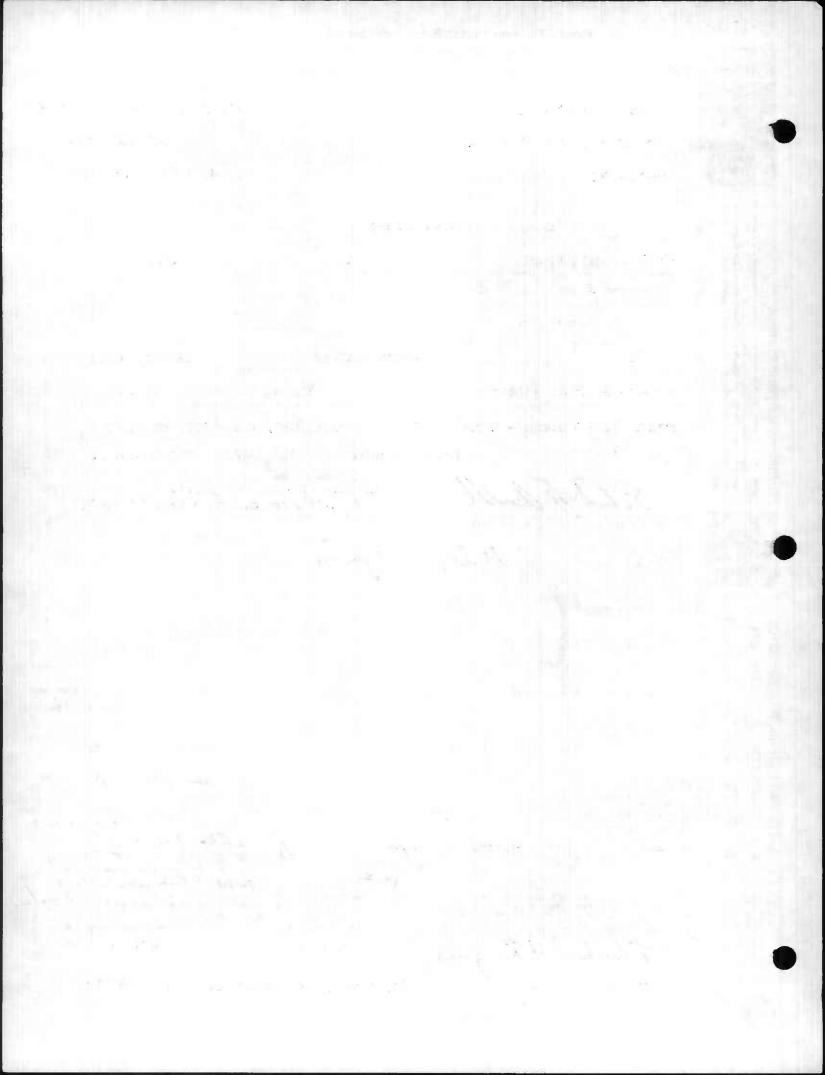
O.C.M.E

MARCH 30, 1998

THEMOLLEMIK 31. Data filad (Month, Day, Year) APR 03 1998

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Ragistrar's Signature



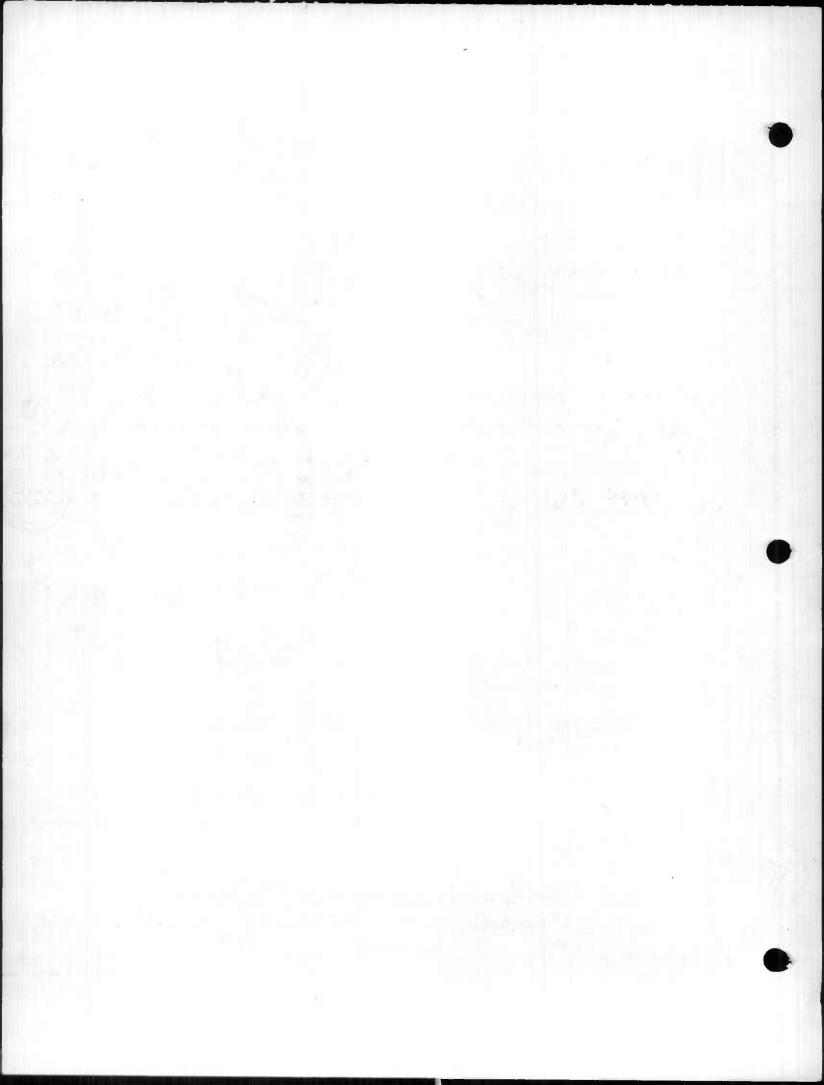
THE FUNDENTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNDENT After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Dept. of Health and Memtal Hypiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERTIFIC	CATE O	FDEATH	REG. NO).	
	1. DECEDENT'S NAME (First, Middle, Last)	2				2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATN
	J MOSES	BALLAR	OSR.				1 199.8	1130 am M
		8. SEX 8. AGE (III		F UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	Cour	THPLACE (State or Foreign ntry) 91 N 1 A
4	Se. FACILITY NAME (If not institution, give street				OR LOCATION OF DE	EATN	9c, COUNTY OF	DEATH TM OR &
5	RESIDENCE OF DECEDENT							
DIME	Md 10b. COUNTY	2		TOWN OR LOC	ation ove			10d, INSIDE CITY LIMITS? 1 YES 2 NO
FKAL	1734 Bond	Stree	+		101, ZIP CODE 2/2/3		10g. CITIZEN OF	WHAT COUNTRY?
BT FUNER	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EYER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	U.S. ARMED 2 NO	If yes,	ECENDENT OF NISPAI apocity Cuban, Maxico ES 2 NO Specti		Bio	CE — American Indian, lick, White, stc.
ED	15. DECEDENT'S EDUCA (Specify only highest grade co	mpleted)	16e. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during	TION most of working	16b. KIND OF BU	JSINESS/INDUSTRY	
COMPLE	12+	College (1-4 or 5+)	-> L	red	PASTON			hurch
BE CO	17. FATHER'S NAME (First, Middle, Lest) Edward B	ALLArd		1	KATI	E Loui		vight
0	19e, INFORMANT'S NAME (Type/Print)	1				Route Number, City or To		
-	MANY TOALLAR 200. METHOD OF DISPOSITION		PLACE AND DATE OF	Bon		CATE 200. B	Cto. Md.	
	1 Burial 2 Cremetion 3 Remove	ni from State cem	alery, crematory or oth	orplace)	CEMETER	y 4/6/98 PE	TER sh	urg VA.
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE		22. NAME	AND ADDRESS OF F	COLITY	BALTO. M.	121213
	23. PART I. Enter the diseases, or con	molications that caused	I the death. Do no	J E /	mode of dying, suc	the secretise or res	UNCKS	Approximate
1	ahock, or heart fellure. Li						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	interval Batween Onset and Death
	disease or condition resulting in death) a.	Acute DUE TO (OR AS A	Myo can	1/4/	In fare	tion		Pays
N	Sequentially list conditions, b.				Failure			Months
CALIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE JO (OR AS A	CONSEQUENCE OF)	:				
ERTIFI	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)	;				
5	PART II. Other algnificant conditions	contributing to deeth b	ut not resulting in	the underly	ring cause given in			4b. WERE AUTOPSY FINDINGS
בטוכא	Olakefes M	ellitus				PERFO	PRMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N: ME	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YES	S □ NO	UNCERTAI	N 🗆		1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	ne)			
2	1 YES 2 NO	1 Propertient 2 ER/Outp			lome 5 - Residence			
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	JRY	INJURY AT WORK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCURED	
9	3 Suicide 6 Could not be 4 Nomicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, farm, st	treet, fectory, o	ffice	28f, LOCATION (Stree City or Town, Stat		el Route Number,
COMPLET	(Grieck Orlly	IAN: To the best of my know						e(s) end menner es stated.
B E	296. SIGNATURE AND TITLE OF CERTIFIER	no				892	> MA	R 3/ /99-7
0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OR	ATH (ITEM 27) (Type, 98 N /	Print)	IWAY .	57E 307	BALTIA	10 PE, MD 21231
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE			, - 5- /		2,00
	APR 03 1998	3 Julian	evidson-Rank	tell				



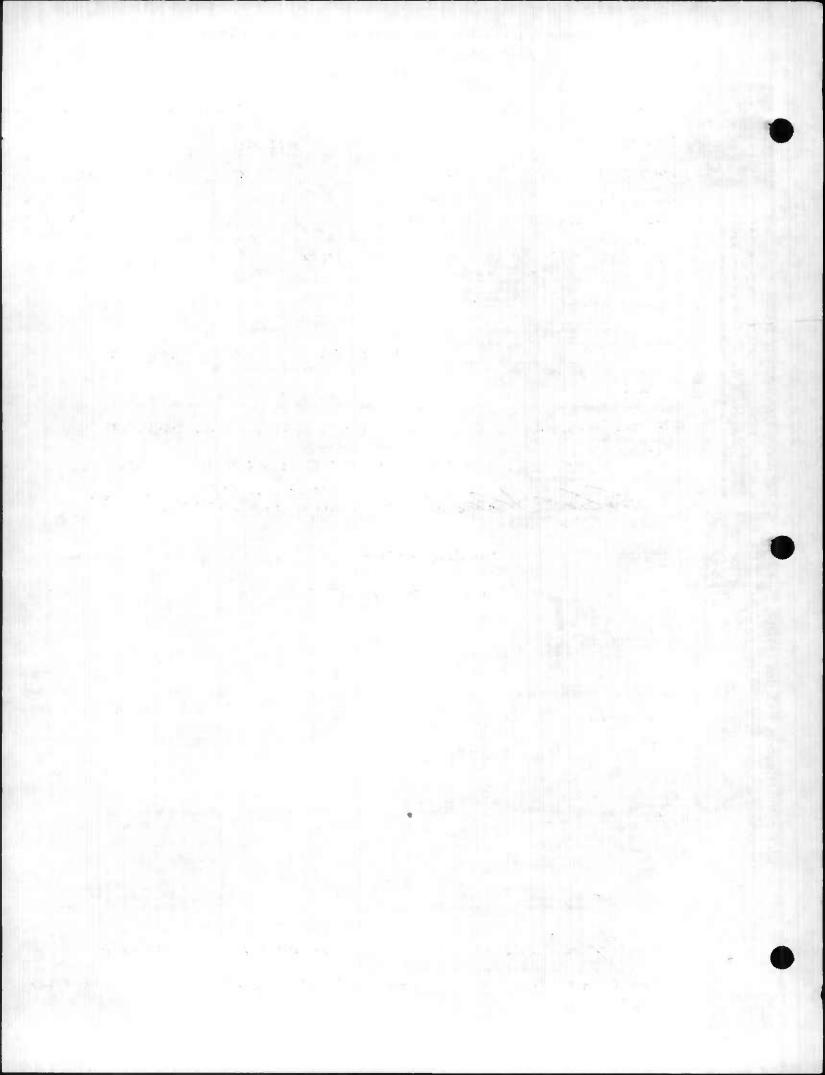
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month **Physician** FRANK 12:23 p.m. BUSKIRK February 9,1998 /Medical 4h City Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 2324 ESSEX STREET BALTIMORE If Under 1 Yeer | If Under 24 Hrs. | 8 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours Min. XXM 2 F Yrs. 213-07-3043 78 Director April 19,1919 MARYLAND Usual Residence of Decedent the Meryland 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-1 show the Mexical Examiner must be notified at XX Yes 2 □ No Directo N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2324 ESSEX STREET U.S.A. 21224 death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Merital Status hours eftar 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE by 3 Ø Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry filed within 75 Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hyglen, Important: If item 27 is marked other that any injury or other traumatic event, Important. SELF-EMLPOYED PRINTING 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) N/A 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY GREENLOW/NIECE 322 S. CHAPEL STREET, BALTIMORE, MD. 21231
ca of Disposition (Name of Date 20c. Location - City or Town, State 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 1X Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) VOSHELL MEMORIAL GARDENS 2/24/98 BALTIMORE, MD. 21. Signature of Funeral Servica Licenses 22. Name and Address of Fecility LILLY & ZEILER INC. FUNERAL HOME 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medicai Cardiae arrest seconds Examiner Due to (or as a consequence of): Physician/Medical Examiner years Coronary Artery Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury P.O. Box 68760 that Initiated events resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? the 8 1 Yes 2 No 3 Probably 4 Unknown Obstructive Disease ð 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed Deed Disease certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Ostpatient 3 ☐ DOA this funeral 27 Menner of Deeth iours efter death.

versi Director: After the filled in by the funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? or Attending 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours 143 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and menner as steted.
2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29e. Certifier completely (Check only 29c. License number 29d. Date signed (Month, Dey. Year) 29b. Signature end title of cartifier 047479 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) JHGC 5505 Hopkins Baywar Circle, Baltimore, MD 21224 Allen Beamer Brock 32 Registrers Signature fur a Day occor-Rendell 31. Date filed (Month, Dev. Year)
APR 03 1998

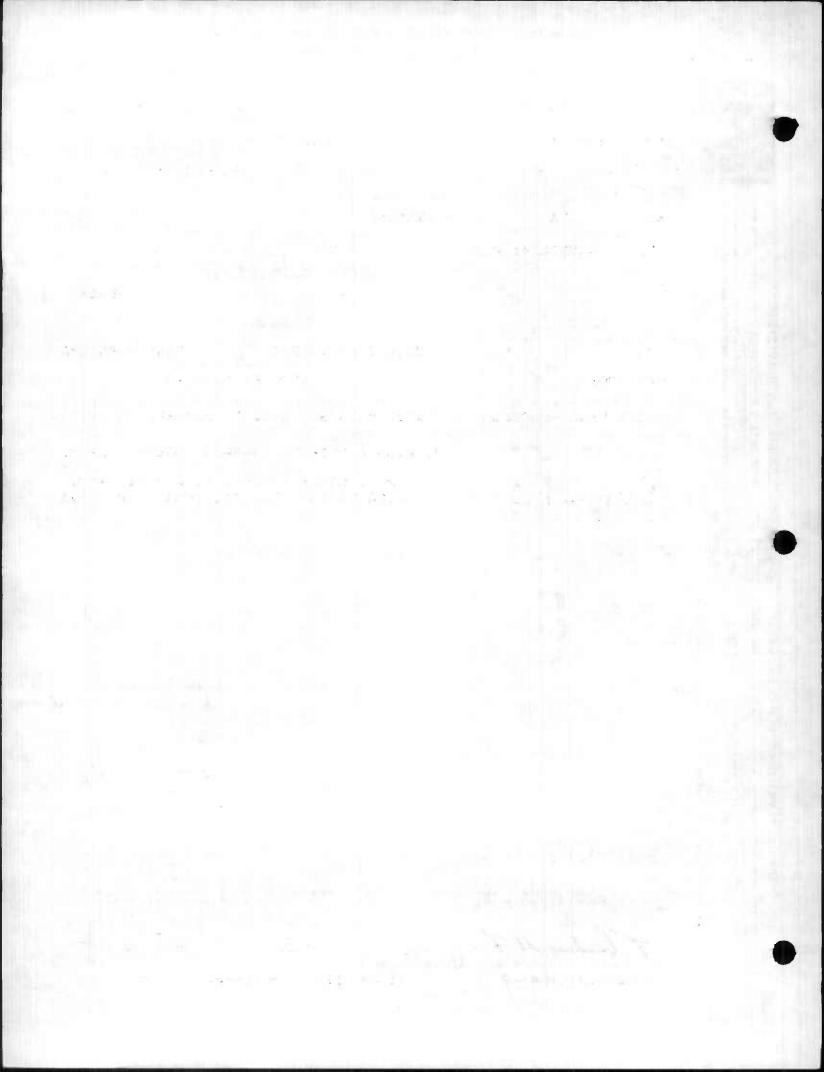
Registrar DHMH 16 Rav 6/95

State



TANYA BOOZI		B part I, ,2			d / Departn 4/24 Certifi				fental Hy	giene	3 1	0492
Ohyalalan	1. Decedent's	Name (First, Middle, L	.ast)						2. Date of D	eeth Day	Year	3. Tima of Death
Physician Medical		DARTANYA	RALPH	BOOZE					MARCH			1038AM
Examiner	4n Engille, Na	me (If not institution, g	ive street and num	nber)					ocation of Dee	th 4c. Cour	ty of Deeth	
	5221 5. Sociel Secu	FLORENCE A		7. Age (In yrs. la	set hirthday) If	Inder 1 Year	BALT:	MORE of 24 Hrs.				place (State or Foreign
Funeral Director		2-4610	1♥M 2□F	48		nths Days			8. Dete of B (Month, D DEC 18	ay, Year)	Cou	place (State or Foreign htry) D
		nce of Decedent									1	
h the Merylend r 28a-f show Looff ad at	10a. State	10b. County			Town or Location							10d. inside City Limits 1 √2 Yes 2 □ No
the M	10e. Street ar	N A	1	BAI	LTIMORE	f. Zip Code				10g. Citizan o	f What Cou	Δ
offer death with the Meinter death with the Meinter 23a or 28a-f and a feet must be notified.	522	1 FLORENC	CE AVENU	JE		212	15		10 7	US		,y.
ter death	11. Merital St	etus	12. Wes Dece	dent Ever in U,S	6. 13. Wes I	Decedent of	Hispanic O	rigin? (Sp	ecity Yes or N		eca - America	
15-0020 72 hours effer death with the Meryland Thatural; or from 23a or 23a-f show calcal Evanthe from the notified at		Merried 2☐ Merried	Armed For 1 Yes If Yes, Give Year or Da	2 🖄 No e		es 2 No			Rican, etc.)		lack, White, hity: BLA	
21215-0020 d within 72 hours of gloon r than "natural", or the Medical Even		15. Decedant's (Specify only highest g			16e. Decedant's	Usuel Occu	ipation	net of work	ina	16b. Kind of	Business/In	dustry
	Elamantary	/Secondary (0-12)	College (1-	-4or 5+)	life. DO N	OT use retin	ed)	ISL OF WORK	"I'g			
			NA_	1	HOME I	MPRO'			a (Cinat Ministra	SELF		OYED
E Saby	TOUN	ame (First, Middle, Las BOOZE	st)						Y LAME	e, <i>Maiden Sum.</i> PKIN	ame)	
re, Maryla s 1 and 2 should if Haaith end Men tem 27 is marke other treumatic		nt's Name/Reletionship	(Type, Print)		19b. Mailing Ad	dress (Stree	et and Num	ber or Rur	al Route Numi	ber, City or Tow	m, State, Zij	Code)
and 2 and 2		HY WALL -		3						IMORE,		21215
ore, N of Haalth item 27	20e. Method			ce	ece of Disposition	(Name of	ace)		Date	20c. Location	n - City or To	own, State
Pages need of land of		I 2 □ Cremation 3 tion 5 □ Other (Spec		MT				4	-6-98	BALT	IMORE	E, MD
Baltimore, It permit. Pages 1 and Deportment of Haath Important: If item 27 any fullury or other to and to be.	21. Signal yre	of Funeral Service Lic	ensee							OME WE		INC.
STATE OF THE PERSON NAMED IN	23a, Par 1, E	nter the disease, or co	mplicetions that ca	used the death						IMORE,	MD	21215 Approximete
Physician			ly one ceuse on ea	ach line.								Interval Batween Onset end Deeth
/Medical Examiner	disease or co	ndition	e. COCAIN	E & NARCO	OTIC INTOX	ICATION	COMPL	ICATIN	IG DROWNI	NG	!	
				Dua to (or	as a consequenc	e of):						
axecuted axecuted in and iel-transit	Secuentially	iet conditions	b	Due to (or	as a consequenc	e of):					<u> </u>	
		ist conditions, to immediate Underlying sa or injury										
P.O. Box 68760, at the death certificate be ax 1 by the attending physician etached for use as the buniel Physician/Medical E:	thet Initiated of	evants	C	Due to (or	as e consequenc	e of):						
Box 6i eath certific attanding p for use as			d								i	
Box eath cert attendin for use												
O a 2 2	Part II. Other	significant conditions	contributing to de	ath but not resu	iting in the underly	/ing cause g	jiven in Par	t I.		Yes 2 No		o the cause of death? bably 4 Xunknow
										2010	, 0,110	one, vo
Records, ne law requires the law requires the law requires the law requires the law requires the law remolected by										s an autopsy formed?	8/	ere autopsy findings raileble prior to
The law require the has been spage 2 should						<u> </u>						ompletion of cause daeth?
- F # 6									*	Yas 2□No	1/2	Yes 2□ No
of Vital I Physician The this certificate ral director, pag. To Be Co.	examiner's	rafarred to medical	Hospital:					ce of Deel	th (Check only	one)		
T di di			1 1 1		PVOutpatient 3 28b. Time of	J DOA		Nursing Ho		how injury occ	-	fy)
ding ding the fune	1 □ Natur	al 5 Pending		h, Day Year)	fnjury	28c. Inj W	ork? ⊒Yes 2√0	□No	Unknown	, non injury ooc	arrod	
Division of a Attending Phase after death. Director: After the din by the funeral din by the funeral certification: "errification:"	3 ☐ Sulci	de 6 Could not	be 28e. Place	of Injury - At hor	inknown me, farm, street, f				28f Location	(Street and Nu	nber or Rur	al Route Number,
Division of standing P as after death. The division of the funer of t	4 🗆 Homi	cide	Resid	ig, etc. (S <i>pecity,</i> lence)					altimore		ence Ave.
To the Hospital or within 24 hours after to the Funeral bir completaly filled in			Physician: To the laminer: On the ba	best of my know sis of examineti					end due to the	e ceuse(s) and	mannar as	
vithin of the complete of the		e and title of certifier		/		29c. Licer	nse number	,		29d. Date sig	ned (Month,	Day, Year)
E > E 0	17	buch	M. K	795 -	-	0	C.M.E			MARCH	30 1	998
	30. Nama and	address of person wh	o complated cause	of death (Item	23a) (Type, Print		J.11.11	•		LESINCII	30, 1	,,,,
	7	HE MORE	Miking		111 Pe	enn St	reet,	Bal	timore,	Maryla	and 21	201
State	31. Date filed	(Month, Day, Year)		egistra s signa	avidson-R	ndell						
Registrar		APR 0	1220	0								

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Items 23 part I,27,28a-f per MEO G-758 4/8/98ertificate of Death	Reg. No.	0493
1. Decedent's Name (First, Middle, Last) Christopher Wayne Brooks	2. Date of Death Month Day MARCH 31, 1998	3. Time of Death 5:02 PM

permit. Pagas 1 end 2 sh Departmant of Haelth and Important: If item 27 is m any injury or o

Physician /Medical **Examiner**

The lew requires that the death certificate be axecuted pue attending physician for usa as tha buna signed by cartificate hes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this cartificial filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

al			CHITIST	phuer A	vayne b	rook	S			MARCH	31, 15	190	5:0	Z PM.
er	4a Facility Name (I	f not institution, PENROSI	From the state of	umber)					Fown, or Lo	cation of Deeth	4c. Count	y of Death		
	5. Social Security N 216 - 50 -		6. Sex 1/∑M 2□ F	7. Age (In yrs. 47	last birthday) Yrs.	If Und Months	er 1 Year S Deys		Min.	8. Dete of Birt (Month, De) 5 - 6 -]	r, Year)	9. Birthp Cour	place (Ster	te or Foreig
	Usuei Residence o	Decedent												
	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside	City Limits
ò	Md	N/A	\		Baltir	nore	2						1 X Y	es 2 No
8	10e. Street end Nu	mher				7	ip Code				10g. Citizen of	What Cour	ntry?	
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ted g	10	15. Decedent's	Education	,	16a. Deced	lent's Us	uel Occu	pation	and and recorder		16b. Kind of E	Business/In	dustry	
pie			grede completed		life. L	DO NOT	use retire	ed)	ost of work	ng	Balti	more	Dept o	of
E	Elementery/Second		1	(1-4or 5+) ar	Tutor	In	str	ucto	r				- '	
Š	17. Father's Name			ai				18. Mot	her's Neme	(First, Middle,	Meiden Surne	me)		
B	Pink Broo													
9								unr	istab	ell Rol	lins			
	19a. Informant's No	ame/Relationshi	ip (Type, Print)		19b. Mailir	ng Addre	ss (Stree	t end Num	ber or Run	al Route Numbe	r, City or Town	n, Stete, Zip	Code)	
	Christat	P11 P	Brooks -N	lother	2142	Pe	nros	e Ave	enue	Baltim	ore, Md	2122	3	
	20a. Method of Dis	position		20b. F	Place of Dispo	sition (N	leme of			Dete	20c. Location			
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	23a. Pert1. Enter to shock, or hee	(Final		NE AND NA	th. Do not ent	er the mo	CATIO	ing, such a	AVENU as cardiac	e Balti or respiratory an	more, I	Md 21	Approximately interval in	
e				Due to (or as a conseq	ineuce o	1):							
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nysician/Medicai Examiner	that Initiated events resulting In death)			Due to (d	or as a conseq	uence of	1):							
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0	Pert II. Other signif	icant condition	s contributing to	death but not res	ulting in the u	nderlying	cause o	iven In Par	t I.	23b. Did 1	obacco use c	ontribute t	o the caus	se of death
										10	Yes 2 No	3 ☐ Pro	bably 4	Unkno
Be Completed by										24a. Was perfo	en autopsy med?	av cc	ere autopi vailable pri ompletion death?	sy findings or to of cause
Com										100	res 2□No	1/	Yes 2	2□ No
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HOU.	27. Manner of Deat 1 Netural 2 Accident	h 5 🗆 Pending investiga		of Injury oth, Day Year) 3/31/98	28b. Time of Injury unknown	М	28c. Inje We 1 [ury et ork? Yes 2)		28d. Describe I Unknow		bernu		
Certification:	3 Suicide 4 Homlcide	6 Could no determin	ot be 28e. Place build	e of Injury - At h			ory, office			28f. Location (S City or Tox				lumber, ve.
دَ			Toun	d at home							Baltimor	e, MD.		

29a. Certifie

one)

Baltimore, MD. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signy

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) APRIL 01, 1998

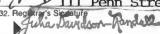
nd address of person who completed cause of death (Item 23a) (Type, Print)

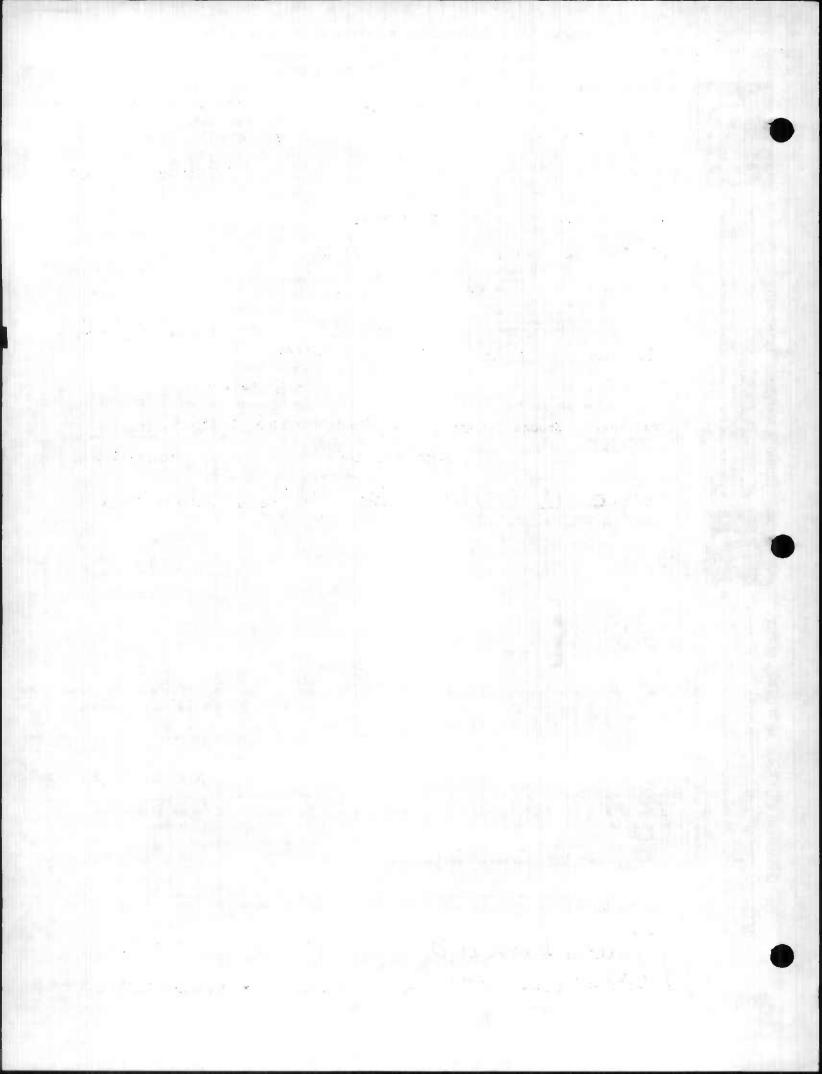
Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year)

Registrar

Medical

APR 03 1998



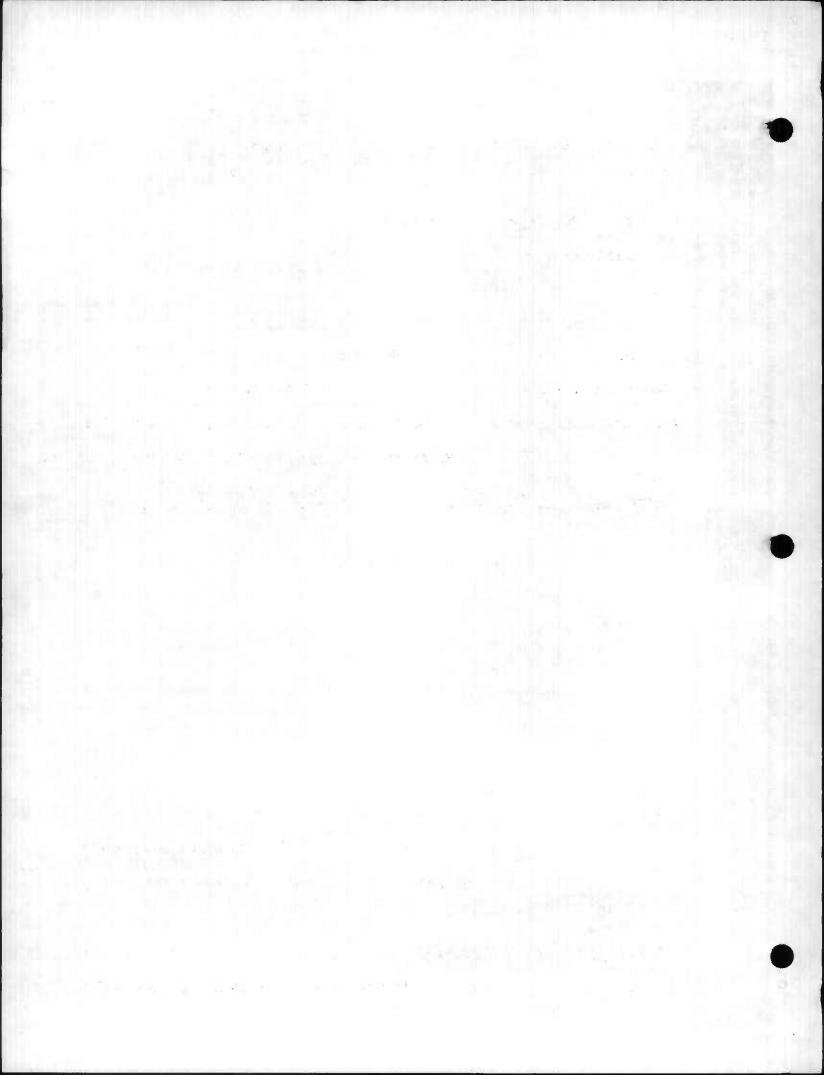


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:50P.M. Brown, James III 1998 4b. City, Town, or Location of Deeth /Medical 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner JOHN HOPKINS BAYVIEW ER. | 7. Age (In yrs. lest birthday) BALTIMORE If Under 1 Yee Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1€M 2□ F Yrs 25 220-04-0818 Maryland Director 09/18/1972 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner name by notified at Yes 2 No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 942 Franklintown Rd. 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours aftar Hygiene. Wher than "natural", or Ita 1 Yes 2000 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory 11th Paint Mixer marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If flem 27 is marked other any Injury or other traumatic event RDEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Brown, Jr. Vicky M. Brown 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) James Brown, Jr. / Father 5010 Goodnow Rd. Baltimore, Maryland 21206 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 4/7/98 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility David J. Weber Funeral Home 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximete Approximete Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Multiple Gunshot wounds disease or condition resulting in death) Examine Examiner requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) attending for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown Records. P 24b. Were eutopsy findings evailable prior to should 24e. Was en eutopsy performed? Completed completion of cause of death? s certificata has t 1 ₹Yes 2 No 1- Yes 2 No Division of Vital Attanding Physician: director, Be 25. Was case referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐XDOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 XYes 2 No this funerai 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 28c. Injury at Work? Certification: 1 Neturel 5 Pending Subject was shet
281. Location (Street and Number or Aural Route Number,
City or Town, State) 1225 Ray leighway 1 Yes 2 No death. 2 Accident Investigation 4-1-98 by the f 2100 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 KHomicide 6 ŏ withing fours aft To the Funeral Di completaly filled in Baltimore City, Maryland Street Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner steted. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (ftelf) 23a (Type, Print) acli APRIL 2, 1998 O.C.M.E. Strohen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's etgneture Andala 31. Date filed (Month, Dey, Year) State APR 03 1998

Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 6,7 Per FH Film G-758 4-3-98RC Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** VERNON RUSSELL CARR SR. 4 25 PM APRIL /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner University Hespital Baltimore 7. Age (In yrs. last birthday) 7.8 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours Min. M 2□ F Maryland 220-05-1142 2/20/19 Director Usual Residence of Decedent 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow Md. Glen Burnie 1 Yes 2 No Anne Arundel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or any Injury or other traumetic event, the Medical Examiner must be in once. U.S.A. 204 1 St. Avenue 21060 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give WW II Yeer or Detes: 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Assembly line worker Bendix Radio 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Alice Gertrude Jelly James Russell Carr 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 204 1St. Ave., Glen Burnie, Md. 21060 Phyllis Carr 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete Maryland Veterans Cem. Apr. 6, 1998 Owings Mills, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Parff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical immediate Cause (Final CEREBRAL HERNIATION SYNDROME 18 HRS diseese or condition Examiner V. Andrew Street, Stre Due to (or es e consequence of): 18 HRS SUBDURAL HEMATOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Fall in bathroom edical Due to (or es e consequence of): Physician 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to 24e. Wes en autopsy performed? Completed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 No 1- Inpatient 2 □ ER/Outpetient 3 □ DOA funeral 27. Menner of Deeth Certification:

68760 Division of Vital Records, P.O. Box certificate or Attanding efter death. Director: Af P filled in

the Marylend

altimore, Maryland 21215-0020

1 Neturel 5 Pending Investigation 2 Accident 3 ☐ Suicide

29e. Certifier

6 Could not be determined 4 - Homicide

28e. Dete of Injury (Month, Dey Year) 3-31-98

MD

28b. Time of un know M 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred

Fell in pathroom 281. Location (Street and Number or Rurel Route Number, City or Town, State) Perry Point VA Hospita) Perry Point Vetran's Hospital (ecil county, naryland 186 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner stated.

(Check only one) 29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year) APRIL 1, 1998

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

POTTS MD 31. Dete filed (Month, Day, Year)

APR 03 1998

22 SOUTH GREENE ST BALTIMORE, MD 21201 32. Registrer's Signeture Juna Daydoon Randale

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month CORNELIUS COLE 5. 04: 401 AM APML 1778 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth NONTHWEST CENTER BALTIMONE HOS11792 PLAMPALLSTOWN 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) May 27, 1924 Birthplece (State or Foreign Country) Deys M 2□ F Months Hours 214-24-9889 Yrs. Maryland Usuel Residence of Decedent 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Md. Glyndon 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4804 Butler Road 21071 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Ares 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electric Electrician 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Amos Wesley Cole Nina Clifta Howard 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marie Cole - Wife 4804 Butler Rd., Glynden, Md. 21071 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from State Maryland Veterans Cem. Apr. 6,1998 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Fur rai Service Licensee 22. Name and Address of Facility 21117 Eckhardt Funeral Chapel
11605 Reisterstown Rd., Owings Mills, Md.

Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel INFARCTION ACUTE MYOCANDIAL 1 HOUR diseese or condition resulting in death) Due to (or es e consequence of): DISEASE ANTERY YEARS CORONARY Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In death) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? ATMAL FUBMILIATION 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Piece of Deeth (Check only one)

Physician /Medicai **Examiner**

Physician

/Medicai

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f ahov the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or Ite

I Hygiene.

other treumatic event,

Depertment of Health and A Important: If Item 27 is ma any injury or other treums

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physiciar the death certificate the the use es signed by 1 Physician/Medical Examiner

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Certification:

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The law requires thet page 2 should certificete has or Attending Physician: After this the funeral death. s efter death in by t

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Robens FINE, MO 31. Dete filed (Month, Day, Year) State APR 03 1998 Registrar

25. Was case referred to medical Hospitel: 1 ☐ Inpatient 2 ★ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

29b. Signeture and also of certifier D47587

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30. Name and audress of person who completed cause of deeth (Item 23e) (Type, Print) RAPORLESTOWN MD 5401 OUD COUNT RUAD

38 Register's Signature Randalle

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene. Int. If Item 22 is or 28a-f show int. If Item 27 is marked other than "naturel", or items 23a or 28a-f show int. If other treatment be notified at any or other treatment be notified at Baltimore, Maryland 21215-0020

> physician and the burial-transit The law requires that the death certificate be executed attending pl for use as t signed by the aid be datached for certificate has blirector, page 2 s or Attending Physician: director. this funeral After death. after deat Director 2 To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

Physician 7:00 PM Ouentin Eugene Copenhaver, Jr. /Medical 4e Fecility Name (If not institution, give street end number) **Examiner** 18602 York Rd. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) March 11, 1939 Birthplace (Stete or Foreign Country) 6. Sex 1 M 2 ☐ F **Funeral** Months Deya Hours Min 59 Yrs. Maryland 220-34-5948 Director Usuel Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No MD Baltimore Parkton Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21120 18602 York Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State Government Body & Fender Repairman 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Mary Anna Matthews Quentin E. Copenhaver, Sr. 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 18602 York Rd., Parkton, MD 21120 Clara Louise Copenhaver/Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete March 21, permit. Pages Department of Important: If its any injury or o 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State Middletown Cemetery Freeland, MD 1998 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name end Address of Fecility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 sed the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, i line. 23a. Pert1. Enter the disease, or composhock, or heart failure. List only o Approximete Intervel Between Onset and Deeth **Physician** MELANOM /Medical Immediate Ceuse (Finel MO diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 W 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Thesidence 6 Mother (Specify) MOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Menger of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Exeminer: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signati nd title of certifie

> ho completed cause of death (Item 23a) (Type, Print) 684A

32. Registrary Signature

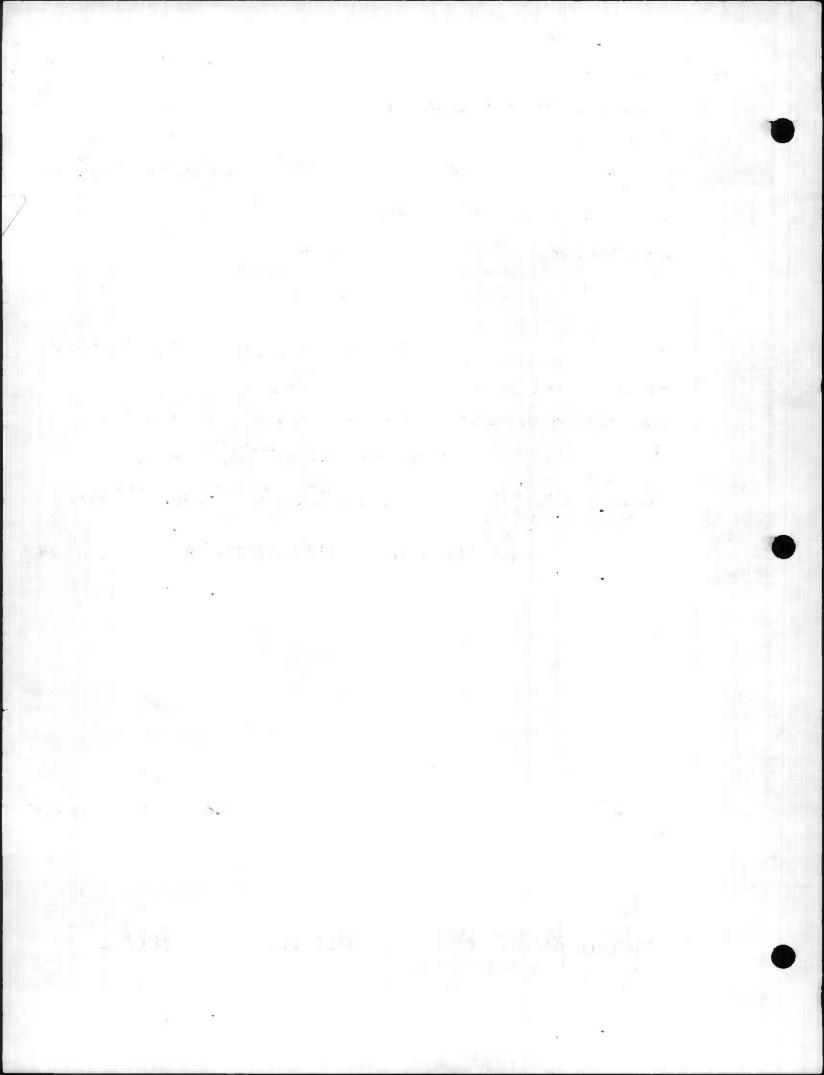
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Westminster, MD 21157

State Registrar

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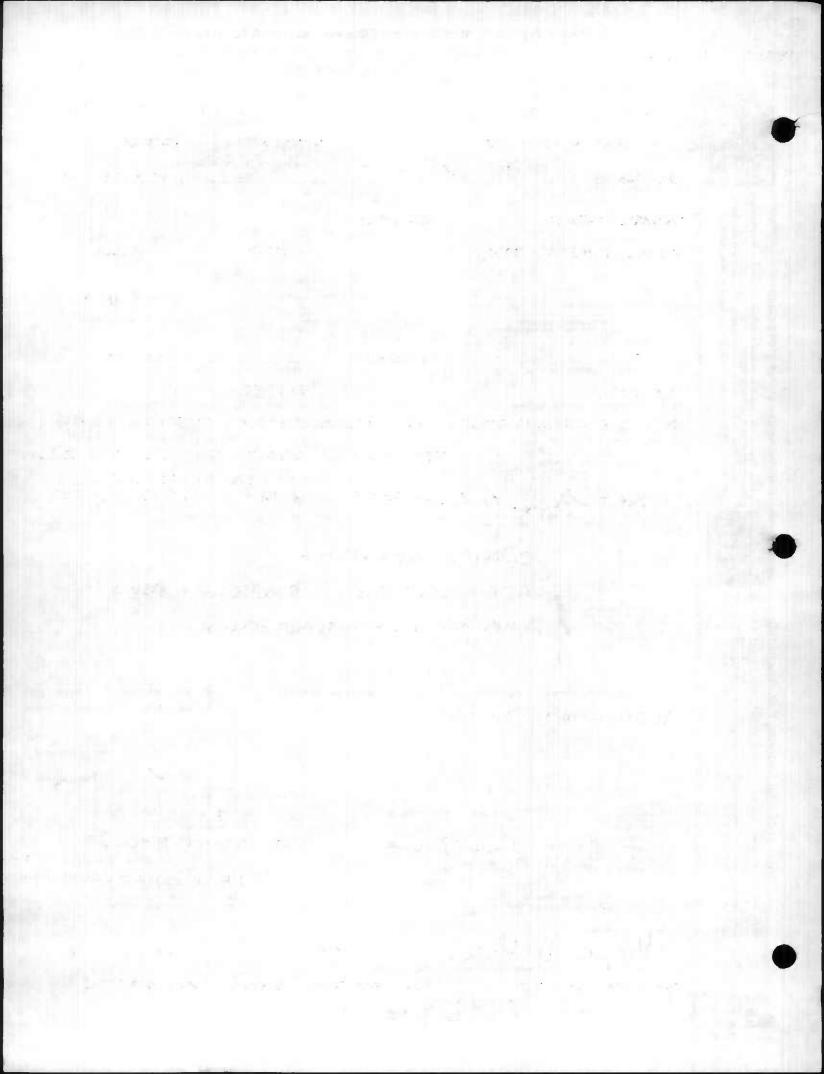
State of Maryland / Der

partment of Health and	Mental Hygiene	10498
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State Registrar Margarita Korell M.D.
31. Dete'filed (Month, Day, Year)

Registracs Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) April 1, 1998 7:30 A.M. Maureen Kathleen Colwell 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (if not institution, give street end number) Baltimore City 5624 Anthony Avenue If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year, Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 1929 North Dakota Months 1 M 2 X F Yrs. 6, 502-24-2642 68 Sept. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore City N/A Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5624 Anthony Avenue 21206 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forcas?

1 ☑ Yas 2 ☐ No
If Yes, Give 2/11/55+ 14. Raca - American Indian, 11. Meritai Stetus Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Bleck, White, atc. 1. Nevar Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Detas: Specify: White 3 ☐ Widowed 4 ☐ Divorced 3/12/56
16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) College (1-4or 5+) Elamentary/Secondery (0-12) Federal Government Claims Examiner 4 Years 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Colwell **Felicitas** Mathias Wilfred Agatha Connor 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 3201 Rosalie Avenue, Baltimore, Maryland 21234 Maureen Colwell/Daughter 20b. Place of Disposition (Name of cametery, cremetory or other place) 4/4/98 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Crametion 3 Removel from State Baltimore, Maryland Gardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 Manita Momas Inter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or raspiratory errest, rhaart failura. List only one causa on each lina. Approximata Intervai Between Onset end Deeth Immediete Ceuse (Finel disaesa or condition rasulting in deeth) Due to (or as a consequence of). Sequentielly list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Due to (or es e consequança of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 7 No 3 Probably 4 Unknown 1 Yee 24b. Wara autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy 1 Yas 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 1 Paturel 20 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Dey, Year) 29c. Licansa number 29b. Signeture and title of certifian

CHANCE ST.

Physician

/Medical

Examiner

Director

Funeral

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Examiner

Physician/Medical

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Completed

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Certification:

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7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at

the Maryland

death

Physician

Box 68750

Division of Vital Records, P.O.

/Medical Examiner

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Funeral P

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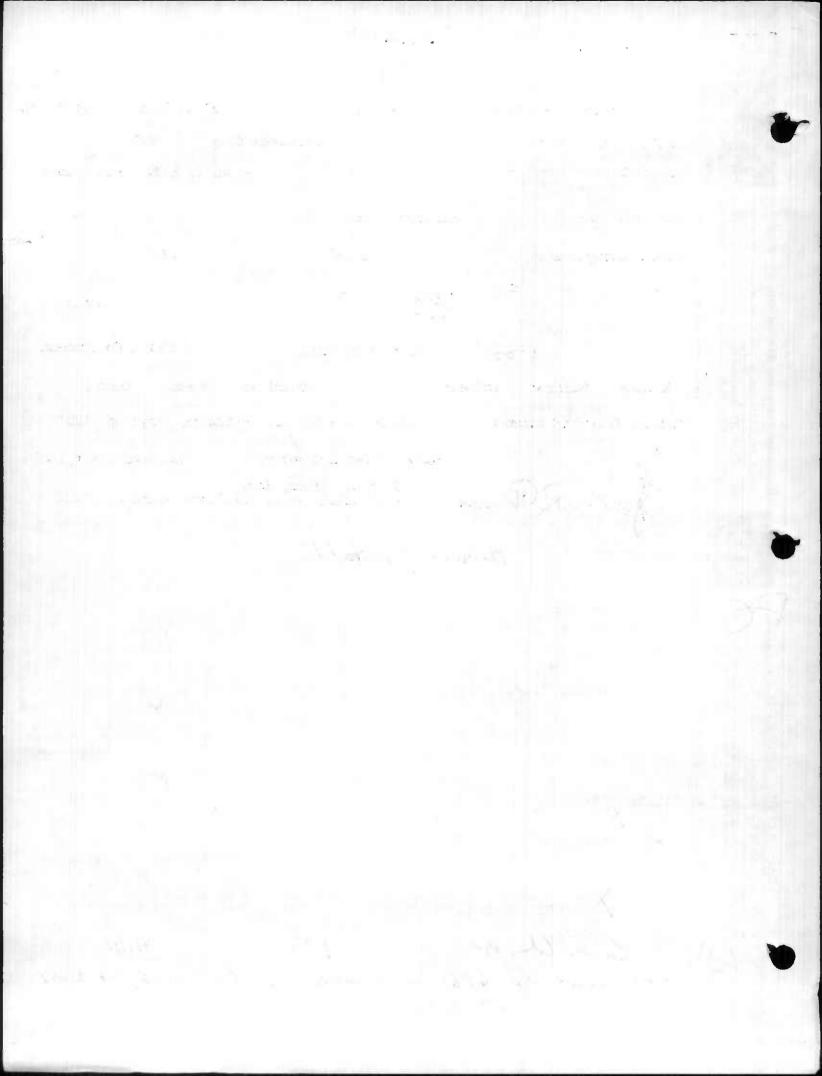
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6569 N. 32. Registrar's Figneture

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Nama (First Middle Last) 2. Date of Death 3. Time of Death Day 1998 Month MARCH 31, Physician MILDRED E. DULY 4:30 P.M. /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, giva street and number) 4c. County of Death Examiner CHESAPEAKE MANOR MEDICAL CENTER ARNOT D ANNE ARUNDEL If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 1 F Vrs. 90 220-56-1955 Director JUNE 14, 1907 MARYLAND Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "natural", or itema 23a or 28a-f ahow the Medical Exampler must be notified at 1 ☐ Yes 2 ☒ No GLEN BURNIE MARYLAND ANNE ARUNDEL Direct 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zin Code UNITED STATES 306 D STREET, S.W. 21061 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. should be filed within 72 hours after and Mental Hygiene. marked other than "natural", or its 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: þ 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 Lith and Mental Hygie 27 Is marked other r traumatic evant, II 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) LILLIAN BOTELER BENJAMIN F. ZIMMERMAN 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s ment of Health an ant: If Itam 27 Is 1 407 3RD AVE., S.E., GLEN BURNIE, MARYLAND 21061 WILLIAM P. DULY, JR. / SON other altimore. 20b. Plece of Disposition (Neme of cemetary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete APRIL 2. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 6 Department of Important: If any Injury or page. GLEN HAVEN MEM. PK. 4 Donation 5 Other (Specify) GLEN BURNIE, MARYLAND 1998 22, Name end Address of Facility M Kunariit Service Licensee KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner eros cle Exam Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760. Physician/Medical that tritiated events resulting in death) Lest Due to (or as a consequence of): 88 use P.O. 23b. Did tobacco use contribute to the cause of deeth? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 21 Division of Vital Records. by 24a. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? page 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation or Attending 1 Netural after death. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide Hospital 24 hours 29e. Certifier t Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. edicai completely 2 Medical Exeminer: On the basis of exeminetion end/or Investigation, in my opinion, deeth occurred et the time, date and placa, and dua to the cause(s) and manner stated. (Check only onel Within 2 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) APRIL 1, 1998 30. Hame and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar esecca

31. Dete filed (Month, Day, Year)

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32. Registratis Signature

ulia Davidson-Randelle

Kn

APR 03 1998

269 PENINSULA FARM RD., ARNOLD, MD 21012

